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PERCY JONES HOSPITAL, BATTLE CREEK, MICHIGAN

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BRUARY 1943

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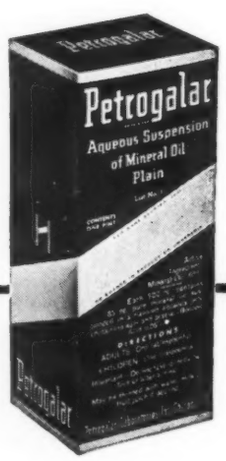

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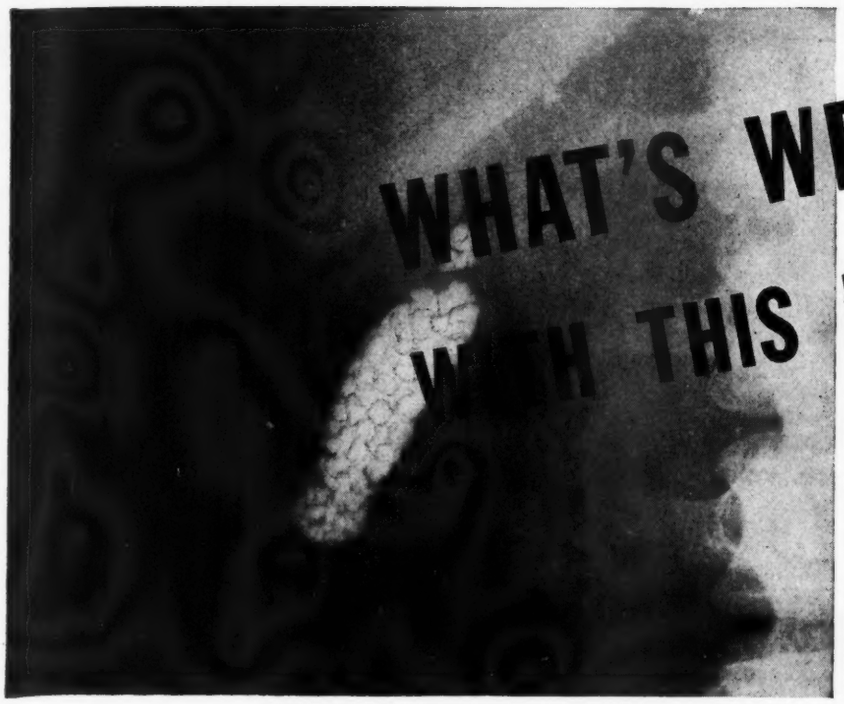

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WAR BULLETINS

PLASMA IN THIS WAR

Guadalcanal—Six men struggle along a narrow, twisting trail bearing a stretcher on which lies a badly wounded Marine. His arm has been torn off by machine gun fire, and to the lay eye he appears lifeless. Behind the little group a viciously contested battle for a strategic hill in the Solomons continues.

Ahead of them, a scant 200 yards behind the front lines at an advance dressing station huddled beneath the trees for cover and protection, another battle is being fought. The Navy Medical Corps attached to the Marine unit is working against death.

As the limp body of the Marine is carried into the station a doctor glances at him and produces two small flasks. One is filled with distilled water; the other with a substance that looks like fine sawdust. Quickly the water is drawn by vacuum into the second flask, forming a straw-colored liquid. The doctor agitates the flask to dissolve all the sawdust-like substance. Then deft hands jab a needle into the Marine's veins. Slowly the liquid drains through a rubber tube.

The process has taken perhaps eight minutes; perhaps fifteen. But as the fluid drains into his body, color visibly returns to the man's face; his pulse quickens perceptibly and his body regains its heat. The regeneration is complete.

The work of the field doctors is done. One more live Marine will go back to the base hospital where he will receive all the refinements of hospital care. With emergency treatments, the doctors have staved off death. Once again plasma has done its work.

Out in the field, the Navy Medical Corps swears by the desiccated blood plasma. It has been established beyond all reasonable doubt that a great number of field casualties would have died from shock or loss of blood had it not been for this simple transfusion.

Plasma is easy to carry and easy to administer, even with the limited facilities of an advance dressing station. Doctors prefer to give the plasma transfusions themselves, but agree that corpsmen are perfectly capable of administering it.

SURGEON GENERAL OF NAVY STUDIES CONSULTANTS' RECOMMENDATIONS

Recommendations on expansion of the program for training naval medical officers in special fields were taken under advisement by Rear Admiral Ross T. McIntire, Surgeon General of the Navy.

Submitted by the Board of Honorary Consultants at the conclusion of a two-day meeting, the report proposes:

1. Training of brain surgeons in Naval Hospitals, under Navy surgeons, with civilian hospitals and teaching personnel being utilized only if limited facilities make this step necessary.

2. Increasing the number of skilled anesthetists, to be achieved, in part, by training and utilizing medical officers of the Women's Reserve. (The commissioning of 60 women medical officers in the WAVES has been authorized, such officers to be assigned to Women's Reserve training schools and stations.)

3. Supervision of optometrists by ophthalmologists-Naval surgeons whose specialty is the eye.

Training of more medical officers in chest surgery, continued emphasis upon physical therapy, and the exercise of care in diagnosing neuroses also were urged by the consultants, whose report was drafted by Dr. Frank H. Lahey of Boston, head of the Lahey Clinic, Chairman of the Procurement and Assignment Service, and former President of the American Medical Association.

PSYCHIATRIC PROBLEMS OF THE WAR*

Probably few of us have much conscious realization of how military activities have affected our mental attitude. Some months ago there was admitted to the University Hospital a patient who had been in the attack at Pearl Harbor. There was no physical injury and yet he was as real a casualty of the war as though he had been hit by a bullet. The incapacitating effects of his disease were greater than in many who were physically injured. For a time even the mention of Pearl Harbor would throw him into a frenzy. Gradually, the wounds caused by this mental injury have healed. No longer does he become disturbed by a discussion of the attack even though he still has a faulty memory of his experiences on that historic date. More than a year of continuous care has been necessary in the treatment of an injury of a type difficult for the average person to understand. This is only one example. Multiply this many times and one begins to realize the importance of preventing such occurrences. Before the war this man had made an adequate adjustment and as a peacetime soldier he had done well. Because he reacted in this way does not necessarily mean that he should be criticized nor that we should think of him as having a yellow streak. This man has a good deal to offer and will again take his place in society. But many others whose personalities are similar and who suffer similarly may become permanent casualties of the war.

As Colonel Halloran, Chief of the Division of Neuropsychiatry of the United States Army, said in a recent psychiatric conference, there has never been an era in the history of the world where psychiatry has been called upon to play such an important and complex rôle. Our country has need for a tremendous coördinated effort in which every man, woman and child must play his part. The mental and physical health of every

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*Radio broadcast by Dr. Raymond W. Waggoner, Professor of Psychiatry, Director of the Neuropsychiatric Institute, Chairman of the Department of Psychiatry, University of Michigan, January 6, 1943, under auspices of Michigan State Medical Society.

(Continued from Page 90)

person must be at its best. For those who have served in the Armed Forces and have been returned to civilian life and those who have been rejected for such service, carefully planned programs should be developed to assist in their adjustment. Individuals who cannot serve in the Armed Forces may still add greatly to the war effort.

It is interesting to note that where civilian morale is high, psychiatric casualties are low and that soldiers from areas of high civilian morale make by far the best soldiers. The maintenance of sound and reasonable discipline is a splendid prophylaxis against psychiatric disability whether soldier or civilian. The Armed Forces recognize the important rôle which psychological factors play in physical conditions, knowing full well that a person physically ill gets well much more quickly if the mental attitude is good. Psychological factors may produce physical illness. The realization of this is important in civil life as in the Armed Forces. Too many people feel that if there is no physical disease, they are to be criticized for their illness. They are always anxious to find some physical explanation for their symptoms. The work of the doctor would be much easier and the patient would receive greater benefit if he would accept the importance of worry, anxiety and nervous tension. These factors can produce disease which has symptoms just as real as though there was pneumonia or appendicitis. So often the patient when told that his difficulty is mental or psychological feels subjected to criticism, that he ought to be ashamed of himself or that the difficulty is in his imagination. That this is not true cannot be emphasized too strongly.

Our Government has spent over a billion dollars in care of psychiatric casualties which occurred in the last war. Even in these days of astronomical figures it is obvious that this expense should be prevented as a consequence of *this* war if at all possible. Psychiatry can help with this problem. Unfortunately adequate psychiatric help is at a premium. However, much has been accomplished; for example, a psychiatric examination is part of the routine at the Army Induction Station. There is a far greater awareness of psychiatric problems in the Armed Forces now than there ever has been before. What about these persons who are incapable of adjusting in the Armed Forces? Are they a total loss? Many of these men are extraordinarily capable in civil life. If their situation is properly and carefully handled, they will continue to make a satisfactory adjustment in civil life.

Consider the person who is registered for Selective Service. He fills out a questionnaire, is examined by the local physician and is then classified by his local board. Both for his own good and the good of the service the questionnaire should contain information about any nervous or mental illness which may have occurred. If the physician finds some mental or physical condition present which would make it impossible to adjust in the Armed Forces, this is reported to the local board who should then wisely and carefully review the situation. If the difficulty is one which according to regulations will not allow the man to enter the Armed Forces, then he ***should not*** be sent to the Induction Station. There are borderline circumstances which require an Army examination. However, this is no place for an attitude such as expressed by one local board recently when the chairman told a registrant that he would be rejected when he went to the Induction Station but that he was going to be sent there anyway. This attitude is most unfortunate.

Psychiatry has an important rôle to play in industrial relationships. Especially is this true in these days of stress when every factory large or small is attempting to produce as much as is possible. The importance of understanding and improving the mental attitudes of workers is expressed in an industrial mental health manual which has just been issued by the Michigan Industrial Mental Health Council. It was pointed out in the preliminary statement of this manual that tension, anxiety and worry which follows the increasing need for production may produce disturbing changes of behavior characterized by preoccupation, quarrelsomeness, indifference and confusion. Such changes result in being absent from work, increase in accidents, ineffectual activity and a drop in production.

Many employers are taking advantage of psychiatric and psychologic advice, realizing the improvement in mental attitude of the worker when this advice is followed and that a satisfied and contented worker produces far more than one who is dissatisfied, unhappy and constantly grumbling.

Perhaps the most important factor in the present war situation which, due to the stress of immediate needs, may be overlooked is the effect of the war upon our children. The problem of the war and its effect upon children and their treatment differs at various ages. The departure of the father for military service or other activity resulting in long absence from the home, the need in many instances for the mother to work in a war plant with day care for the child, all strike at the most important element in the development of the young child; that is, the sense of security.

A certain amount of fear is healthy. When we describe any person, child or adult as having no fear we are probably not being accurate in our description. He may show no outward evidence of fear but the very adequateness of his behavior may be his reaction to fear. Controlled fear then is a healthy emotion driving us to build defense against injury. In a child, fear should not be allowed to develop to the point of anxiety. If he hears his elders talking about the war, expressing their doubts and anxieties, then the child feels insecure. In the very young child, this may cause a return to an earlier developmental level with a loss of many of the good habits that have been learned, the development of aggressiveness associated with destructive tendencies, or in temper tantrums. If the home has in the past offered security, then simple reassurance is enough. It is unwise to try to keep the war away from these children if they ask questions about it. The unknown holds grave terrors for children of this age. One young four-year-old whose mother talked

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about working at the Willow Run Bomber Plant became quite concerned about this possibility. This child did not mind having the mother work elsewhere, but the Bomber Plant was a symbol of the war, a threat to security, therefore, could not be tolerated. Most of us have little realization of the amount of thought and brooding which may go on even in a very small child's mind. Idle or careless words, even if spoken in jest, can easily upset the security of a youngster.

In the elementary school group the mechanism of disturbed behavior is essentially the same; that is to say, recognized or unrecognized feelings of insecurity, but the outward manifestation may assume a different form. There may be a desire to run away from the reality of the situation and to deny the existence of danger. This, of course, is unhealthy and should make the parent or teacher suspicious of the development of a serious mental illness. More commonly, however, the insecurity is expressed in aggressive, hostile or destructive behavior. The playing of war games with the actual danger of injury to playmates may be an expression of hostility to the environment. Here simple reassurance is not sufficient. Hostility and aggressiveness, the behavior activated by anxiety must be directed into useful channels. Children of this age take to constructive activities with enthusiasm if they feel them to be of value. Useful wartime activities, such as sale of war stamps or collection of scrap metal is good mental hygiene.

The problem of the adolescent is more complicated. He or she is old enough to make active plans for the future. The war is a direct threat to these plans. We must all accept the reality of life and build for the future no matter what our present situation may be. Constructive activities tend to dissipate pessimism and pessimism may be a very destructive attribute. In the adolescent the fear and anxiety which produces insecurity may take the form of doubt about the future, the ability to continue in school, the possibility of establishing a future home. As the adolescent matures emotionally there is normally some resentment against authority. The great restriction of his usual activities during wartime tends to increase this resistance to authority. Adolescents react to war in many different ways—some consider it useless to continue school, wanting to get jobs while good jobs are offered; some enter into early marriages; others express aggression, hostility and rebellion against authority by the formation of delinquency patterns. Delinquency has seriously increased in England and is on the increase in this country. In our plans for the future, these factors must be kept in mind. The children of today are the citizens of tomorrow and even though we are thoroughly engrossed in war activities, our planning councils must make blue prints for the future which will include the normal development of our children. The children of today deserve an important place in our plans for the future.

War is a new and disrupting factor in our lives. It upsets our everyday living by the development of restrictions, routines and disciplines that are new to us in our democratic way of life. There are destructive factors which are separate and distinct from injury to men and property. There is an increase in environmental stress. Everyone is required to accept more responsibility. There is more work with less leisure than before. There is a continuous threat to the emotional, physical and economic security of the individual which leads to the development of psychiatric disabilities. Misconceptions and rumors, feelings of mistreatment or inequalities are bound to exist and in some who have feelings of this sort as a part of their personality, such feelings may become markedly exaggerated. All of these things may lead to the development of misdirected, aggressive and hostile attitudes. Some mental ills may be prevented by the maintenance of as great a feeling of security as possible. In the very young child this may be accomplished by simple reassurance. In the grade school child, the adolescent and the adult, the sense of security may be stimulated and improved by the direction of energy into useful channels. Good care of the individual's physical needs with regular habits is wise. Sound rational thinking is important. Confidence in ourselves and our leadership with a refusal to listen to or spread gossip or rumors is necessary. Prevention is always better than cure, so with the first sign of maladjustment in child or adult, immediate steps should be taken to prevent more serious problems.

A DOCTOR'S PLEA IN WARTIME

The doctor's life, in times like these,
Is not exactly one of ease.

For, on the home front, each M.D.
Is busier than any bee!

He's shouldering the burden for
The other docs, who've gone to war.

This leaves your doctor precious little
Time to sit around and whittle.

And indicates the reason why
You ought to help the poor old guy.

HOW?

1. By keeping yourselves in the best of condition
   Thus avoiding the ills that demand a physician.
2. By phoning him promptly when illness gives warning,
   But—unless very serious—waiting till morning.
3. By cheerfully taking whatever appointment
   He makes for prescribing his pills or his ointment.

4. By calling on him where he works or resides
   Instead of insisting he rush to your sides.
   (Of course, he'll come 'round when there's need for his service
   But spare him the trip when you're nothing but nervous.)

5. And, last but not least, you can help in this crisis
   By carefully following the Doctor's advices.

If these commandments you'll adhere to
A doctor's heart you will be dear to!

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1. Fabricant, M. D.: "Nasal Medication," Williams and Wilkins Company, October, 1942.

*Trade Mark Reg U. S. Pat. Off.

CIBA *Pharmaceutical Products, Inc.*
SUMMIT, NEW JERSEY

COUNCIL AND COMMITTEE MEETINGS

January 7, 1943—Preventive Medicine Committee—Statler Hotel, Detroit
January 14, 1943—Mental Hygiene—Detroit
January 14, 1943—Legislative Committee—Hotel Olds, Lansing
January 16-17, 1943—The Council—Statler Hotel, Detroit
January 23, 1943—Medical Preparedness Committee
January 24, 1943—Special Committee on Vocational Education, Hotel Olds, Lansing

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COUNTY MEDICAL SOCIETIES

Bay—January 13, 1943—Wenonah Hotel—Motion picture of "Peptic Ulcers."

Calhoun—December 2, 1942—Hart Hotel—Election of officers. January 5, 1943—Hart Hotel—Motion picture shown on "Peptic Ulcers."

Dickinson-Iron—January 7, 1943—Riverside Club—Panel discussion on Obstetrics by Drs. Addison, Anderson, Fiedling and Huron.

Genesee—January 12, 1943—Elks Club—Business Meeting.

Ingham—January 19, 1943—Hotel Olds, Lansing—Presidents' Night—Speaker: James K. Pollock, M.D.

Jackson—January 19, 1943—Hotel Hayes—Speaker: Clark D. Brooks, M.D., F.A.C.S. Subject: "The Diagnosis and Treatment of Acute Abdominal Emergencies."

Kalamazoo—January 19, 1943—Public Library Building—Speaker: Arthur C. Curtis, M.D. Subject: "What To Do With The Patient With Positive Serology."

Kent—January 12, 1943—Browning Hotel—Speaker: Thomas F. Mancuso, M.D. Subject: "Industrial Health and Occupational Hazards."

Oakland—January 6, 1943—Kingsley Inn—Speakers: C. G. Darling, M.D., George Curry, M.D. Subject: "Treatment of Compound Fractures."

Ottawa—January 12, 1943—Warm Friend Tavern—Speakers: Frank L. Rector, M.D., V. L. Van Duzen, M.D.

St. Clair—January 12, 1943—St. Clair Inn—Motion film shown on "Gastric Ulcer."

Washtenaw—January 12, 1943—Michigan Union—Speaker: M. H. Seevers, M.D. Subject: "The Clinical Classification of The Barbiturates."

Wayne—January 4, 1943—Lecture Hall, Art Institute—Speaker: James E. Paullin, M.D. Subject: "The Contribution of American Medicine to the Present War Effort."

January 11, 1943—Art Institute—Speaker: Harry L. Alexander, M.D. Subject: "Present Concepts of the Mechanism and Treatment of Bronchial Asthma."

January 18, 1943—Art Institute—Speaker: Charles H. Lawrence, M.D. Subject: "Disturbance of Androgen Estrogen Balance, Their Significance in Clinical Medicine."

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Newer Treatment of Common Skin Diseases*

By Carroll S. Wright, M.D.
Professor of Dermatology and Syphilology
Temple University School of Medicine
Philadelphia, Pennsylvania

CARROLL S. WRIGHT, M.D.
B.S., University of Michigan, 1917; M.D., University of Michigan, 1919. Instructor in Dermatology and Syphilology University of Michigan Medical School, 1920-1922; Associate Professor of Dermatology and Syphilology Graduate School of Medicine, University of Pennsylvania. Professor of Dermatology and Syphilology Temple University School of Medicine. Consultant Dermatologist to Philadelphia Municipal Hospital; Widener School for Crippled Children; Shriner's Hospital; Pennsylvania Institute for Blind; Pennsylvania Institute for the Dumb; Vineland Training School. Trustee of Research Institute of Cutaneous Medicine. Associate Editor of the "Medical World" and "The Weekly Roster and Medical Digest." Member of American Dermatological Association, Society for Investigative Dermatology, American Academy of Dermatology, Philadelphia College of Physicians, Nu Sigma Nu and Sigma Xi. Author of textbooks "Treatment of Syphilis" with Dr. Jay F. Schamberg and "Manual of Dermatology" and numerous contributions to dermatological literature.

TWENTY-FIVE years or more have passed since a prominent Philadelphia dermatologist, now deceased, jokingly referred to his specialty as one in which patients never call their physician at night, never die and never get well. As a practicing dermatologist in Philadelphia this saying was quoted to me so many times and so often used as a basis for patients assuming that their particular skin disease could never be cured, that I felt compelled in 1938 to write an editorial for the *Medical World* on "The Curability of Skin Diseases." Present-day statistics indicate that the ten most common skin diseases seen in any physician's office are as follows: eczema (including dermatitis venenata), acne vulgaris, scabies, ringworm, seborrhea, impetigo, psoriasis, urticaria, verrucæ and skin tumors. These are not given in the exact order of their comparative frequency, but collectively they comprise perhaps 60 to 75 per cent of all skin diseases. Since the turn of the century remarkable studies have been made in the treatment of skin diseases, and numerous of the above named conditions which were regarded as responding poorly to treatment or regarded as entirely incurable, are now either curable or capable of control to an extent that severe complications or irremediable sequelæ need not occur. The following review covers a few of the newer ideas concerning these conditions, and both old and new methods of treatment follow.

*Presented at the Seventy-Sixth Annual Meeting of the Michigan State Medical Society, Grand Rapids, Michigan, September 19, 1941.

Eczema and Dermatitis Venenata

For centuries the term "eczema" was used to include a multitude of skin diseases and constituted the scrap heap of dermatology. Time has seen the salvaging from this scrap heap, of a number of diseases of the skin that are now recognized as separate entities—such as scabies, ringworm of the hands and feet, dermatophytids, seborrhea, infectious eczematoid dermatitis, monilia infections and monilids and various types of contact dermatitis which are still often listed as eczemas (occupational eczema, etc.). This subject is too broad to possibly consider in the allotted time all the various clinical phases and therapeutic procedures, but it may be safely stated that newer concepts of eczema have made virtually all types more amenable to study and treatment, and there are few cases in which relief cannot be promised even though a cure may be impossible. Improvement in the means of detecting etiological factors by means of percuta-

neous, intracutaneous and patch tests, often leads to the elimination of causes and decreases the likelihood to further attacks. Consideration must be given to the relationship of outbreaks to (1) ingestion of certain foods and other allergens, (2) articles of clothing (silk, wool, rayon, nylon, et cetera), (3) dusts, (4) overwork and worry, and other less common factors. In all atopic types of eczema, and particularly in eczema of children, elimination diets such as those suggested by Rowe, are worthy of trial. The development of *soybean* milk as a substitute for milk in infant feeding has contributed much to the successful treatment of those cases of infantile eczema that are traceable to cow's milk.

Acne Vulgaris

One of the most easily recognized of all skin diseases, acne vulgaris, is at the same time one of the most neglected and my office statistics show that in the majority of cases which finally seek medical aid, either the family doctor or one or both parents, and at times all three, have taken the attitude that acne is an unavoidable accompaniment of adolescence and must be suffered in silence until nature finally brings about a spontaneous cure. By the time that a spontaneous cure takes place (and sometimes this never occurs), a fairly large percentage of the affected youths will have suffered marked pitting and scarring, equal at times to that produced by smallpox. They may have also developed a persistent inferiority complex. I have always urged that adolescent youths with acne should receive the same prolonged care of their skin that is given to the straightening of crooked teeth and I know that the result will be equally gratifying and the expense considerably less. Neglect by the medical profession drives many young boys and girls to self-medication or to seeking relief in barber shops, beauty parlors, drug stores and other sources not qualified to deal with the medical aspects of the disease. The modern day treatment of acne vulgaris requires consideration of:

1. Developmental changes and endocrine factors.
2. Dietary regime and attention to the proper functioning of the gastro-intestinal tract.
3. Attention to the general health (Tonics, Vitamin D or Vitamin B Complex)
4. Proper hygiene of the skin. (In most cases this means the thorough use of soap and water and removal of blackheads, preferably by the physician.)
5. Control of local infection (sulphur or mercurial lotions or ointments). (Vaccines or foreign protein therapy at times.)
6. Control of overactive sebaceous glands (x-ray therapy in proper hands is perfectly safe and at times the only methods of controlling sebaceous gland overactivity).
7. Attention to the scalp.

(An oily or a scaly scalp is a definite source of aggravation to acne.

I would urge upon every physician—Begin the treatment of all cases of acne as soon as recognized, with every weapon possible except x-ray, which should be immediately employed if the eruption proves intractable and before irreparable scarring results.

Scabies

Scabies, usually easily cured with sulphur, has recently been treated with newer and more elegant methods including (1) sodium thiosulphate plus dilute hydrochloric acid; (2) benzyl benzoate and (3) rotenone. According to the recent studies of Ingels the safety margin of the benzyl benzoate cure has a great advantage over the sodium thiosulphate cure, and consists of rubbing into the skin with a soft brush a solution of equal parts of benzyl benzoate, sapo mollis and isopropyl alcohol.

Ringworm

The type of ringworm infection seen chiefly today is that involving the hands and feet, and it is interesting that very little was known about this type of fungus infection until the present century. Since World War I ringworm of the hands and feet has become so common that it is now estimated that approximately 75 per cent of all individuals have been infected at one time or another. Early recognition and proper treatment of this infection may prevent the development of one or several complications which include (1) the development of a generalized rash or dermatophytid, (2) lymphadenitis, (3) cellulitis, (4) phlebitis and (5) erysipelas. While all types except that caused by the Trichophyton purpureum may be regarded as curable, no cure-all has ever been found. Treatment depends chiefly upon the type and stage of the eruption and is briefly as follows:

A. *Vesiculo-bullous* (acute type)
   1. Incision of all lesions to promote outward drainage

2. Foot baths or continuous wet dressings of potassium permanganate (1-4000 solution), saturated boric acid solution or liquor aluminum acetate (Burow's Solution)
3. Avoidance of all strong applications such as Whitfield's Ointment

B. *Dry squamous and intertriginous type* (usually secondary to vesiculo-bullous)
1. X-ray therapy: one or several fractional doses
2. Castellani's paint
3. Desquamating ointments (one half to full strength Whitfield's Ointment)

C. *Chronic hyperkeratotic type*
1. Strong desquamating ointments. An ointment composed of equal parts of salicylic acid and lanolin applied on gauze and bandaged in place for three-day periods often acts miraculously.

Refined proprietary modifications of such simple formulas as Whitfield's Ointment may be employed successfully at times, but one should always know the ingredients and their relative strengths in such preparations and employ them only at the proper time.

Seborrhea

Controversy over the etiology of seborrhea, which may vary from a simple scale or dandruff of the scalp to a severe eczematization involving scalp, face, ears and even the trunk, still rages. Sulphur, used for generations, continues to be the sovereign remedy for seborrhea of the scalp and if the outbreak in the scalp is controlled the eruption elsewhere is fairly easily controlled by simple, mild, antiseptic remedies. An effective remedy is sulphur and salicylic acid incorporated in a relatively new base as follows:

℞	Sulphur ppt.	℥i
	Acidi Salicylic	℥ss
	Aquaphor	℥ $\frac{1}{i}$

If this is applied to the scalp each night and followed by a morning shampoo, seborrhea soon disappears and may be completely controlled by an occasional application. Recent studies indicate that the development of seborrhea is favored by a deficiency of vitamins B and possibly narrows down to a deficiency of pyridoxine or Vitamin B_6. Vitamin B Complex has been found to be of value in the treatment of seborrheic conditions.

Impetigo

The medical profession was long dependent upon mercurials for treatment of impetigo and these are still effective remedies, but too often produce a secondary dermatitis. Recent years have seen the introduction of gentian violet used either in a 1 or 2 per cent aqueous solution or a 1 or 2 per cent paste, but this remedy is most unsightly. Recent studies indicate that sulfathiazole incorporated in 5 to 20 per cent strength in a jelly or vanishing cream base is both effective and non-irritating. Other skin infections such as coccygenic sycosis, infectious eczematoid dermatitis, pustular acne and furunculosis also respond to sulfathiazole applied locally and there is evidence that applied as a powder it may prevent infection in burns and thus promote healing. There is also some evidence that the green chlorophyll of plants is an effective agent in skin infections. It has the advantages of not being unsightly and never provoking irritation.

Psoriasis

Of the ten most common dermatoses only psoriasis must be regarded as entirely incurable and will probably continue to be incurable until the etiology is known, but satisfactory therapeutic results are usually obtainable, even though recurrence is the rule. From the standpoint of therapy, psoriasis should be considered as (1) active or (2) inactive. In the active stage the patches are inflammatory, often widespread with new lesions constantly appearing and may be accompanied by local discomfort and itching. In this stage the usual psoriasis remedies such as arsenic internally and chrysarobin and its derivatives externally either aggravate the eruption or are ineffective. Measures used to change the active to the inactive stage consist of (1) Rest, (2) Low-fat or low nitrogen diet, (3) Autohemotherapy (withdrawing 10 c.c. of venous blood from the patient's arm and its immediate reinjection into the gluteal muscles), (4) colloid, sulfur or tar baths and (5) the local application of simple soothing ointments. Once the inactive state is reached, chrysarobin or its derivatives such as neorobin or anthrarobin may be employed in gradually increasing strengths. Vitamin D in massive doses, for a brief time highly extolled, has proved disappointing. Recently, Madden has recommended injections of Vitamin B_1 and Liver Extract. Soybean lecithin by mouth is the most recent recommendation.

Urticaria

Acute urticaria has been and is now a relatively simple therapeutic problem and is often

cured by home measures including diet and free elimination. Chronic cases are often difficult of solution. From the standpoint of etiology the majority are either due to food allergy, or disturbances of the nervous system and must be treated accordingly. Recently, considerable interest has centered in treatment with histaminase. Of seventeen cases treated with histaminase by Laymon and Cumming at the University of Minnesota, 10 were cured, 2 were improved and 5 were unimproved. Histaminase by mouth has not proved of demonstrable value.

Verrucae

Several clinical forms of warts are recognized, most important of which are the common wart or verruca vulgaris, the plantar wart, and the flat or juvenile wart. There are laymen and even physicians who have claimed the ability to cure warts by auto-suggestion. (My own experience is that it commonly fails.) The past quarter-century has seen the following medications suggested for general treatment of verrucæ; (1) Neoarsphenamine intravenously; (2) Bismuth intramuscularly and injected directly into the wart; (3) Sulfarsphenamine intramuscularly; (4) injections of distilled water; (5) intracutaneous injections of cow's milk; (6) autohemotherapy and (7) vaccines made of ground up warts.

Plantar warts are often troublesome and may require trial of several treatments before cure is obtained. I have found the best treatment to consist of paring away the tissue until small bleeding points appear, followed immediately by unfiltered x-ray or radium therapy, preferably the latter. Large plantar warts may be reduced in size by repeated light fulguration and finally x-ray or radium. Surgery is the court of last resort but may be resorted to for extensive growths or lesions that may have been overtreated by x-ray or radium. Grafting is usually required following removal of the growths.

Skin Tumors

Nevi, Keratoses and Skin Carcinoma

Under this heading could be included a large number of conditions of the skin but discussion here will be limited to nevi and malignancies. Of the nevi often designated as "birth marks" and appearing in the infant, interest centers chiefly around vascular lesions. Port-wine marks remain an unsolved problem but elevated vascular nevi may now be treated by (1) radium, (2) carbon dioxide snow, (3) sclerosing injections and (4) surgery. Small lesions such as the so-called strawberry marks are best treated by carbon dioxide snow, but larger lesions such as the cavernous angioma respond better to radium or sclerosing injections or a combination of these two therapeutic procedures. Treatment should be instituted as soon as the lesions are recognized as they tend to enlarge as the child grows.

The dermatologist does not recommend that other types of nevi, such as nevus pigmentosus or nevus pilosus necessarily be removed, but all nevi subject to chronic irritation are best eradicated and those of blue-black color should be removed by wide excision because of the danger of melanoma.

There is no excuse today for the development of incurable skin cancer. Any growing persistent lesion of the skin in an elderly patient should be regarded with suspicion and preferably removed and examined microscopically. The development of the method of destroying skin growths by electrofulguration and their removal with electric cutting currents have advanced to such a degree in the past 20 years that removal of skin growths is today a relatively simple procedure. Also the understanding of the method of application of radium and roentgen rays is greatly advanced and both are at times of great value in the treatment of premalignant and malignant conditions of the skin in expert hands.

Comment

The purpose of this presentation is to show that of the skin diseases most commonly seen, virtually all may be helped or cured by modern day methods of treatment. The day when dermatology was considered a mystic science, poorly understood and unworthy of careful consideration by the general practitioner of medicine has passed. Virtually all medical schools today recognize the importance of the subject in relation to medicine and surgery and indeed all branches of medicine have separate departments for its teaching. Remember—no patient is more grateful to his physician than one who is relieved or cured of an unsightly troublesome disease of the skin.

Regional Enterocolitis*

A Report of Thirty-one Cases

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The authors report thirty-one cases of regional enterocolitis and emphasize investigation of recurrent cramplike pains for this condition. The earliest roentgen signs consist of abnormal irritability and disturbed mucosal pattern of the ileum, later the ileum is rope-like in appearance. The pre-operative diagnosis is often appendicitis and the authors advocate adequate incision in order to explore for regional enterocolitis, Meckel's diverticulitis, mesenteric adenitis and pelvic disease.

A thorough acquaintance with regional enterocolitis will prevent much morbidity and mortality in its management. Early cases do satisfactorily on medical regime, radical resection being reserved for the advanced cases with stenosis and complications.

A distinct disease entity, which they named regional ileitis, was described by Crohn, Ginzburg and Oppenheimer[4] in 1932. They claimed no priority in observing such a condition, as previous reports had described several ill-defined groups of benign granulomas of the intestine; however, they were the first to recognize it as a definite clinical and pathological picture. Since then many reports of this disease have been published, not only under its original name, but also as regional enteritis, terminal ileitis, non-specific ileitis, non-specific ileocolitis, and others.

We chose the term regional enterocolitis because of the location involved in our cases:

Ileum and colon	14
Ileum alone	11
Colon alone	5
Ileum and jejunum	1

The cases in this series were all observed in Harper Hospital, or in the private practice of one of us. All but nine cases were under our personal observation.

The purpose of this paper is not only to report our experience with this disease, but also to emphasize a conclusion which we think is important. This condition is not entirely a surgical problem, as 25 per cent of our cases, after an early diagnosis, show no extension of the disease under judicious medical management and observation.

TABLE I. AGE INCIDENCE

Age	No. Cases
10-19 yrs.	3
20-29 yrs.	11
30-39 yrs.	8
40-49 yrs.	6
50-59 yrs.	3

Age, Sex and Race

Table I gives the age incidence of the onset of the disease, the average age being thirty-two years. This confirms the findings of previous observers, that younger people are the more frequent victims, 72 per cent of our patients being under forty years of age. This is in contrast to the age incidence encountered in carcinoma.

Nineteen of our thirty-one cases were females. Eight were Jewish and there were no negroes. The sex and racial incidence, we feel, is of no importance.

Etiology

As none of the theories regarding the etiology of this disease have been substantiated, and as there is no constant factor which might be considered as etiological in studying our group of cases, we will eliminate further comment.

Pathology

The early cases were characterized by a thickened, edematous, soggy, doughy, mottled appearance of the affected bowel. There was no free peritoneal fluid or serosal exudate present in any of the early cases. There were no microscopic examinations in these early cases, as conservative treatment and observation were deemed advisable. In one case involving the jejunum and ileum in skip areas the mesenteric glands were much more enlarged than in the other cases.

The advanced cases varied in appearance from a thickened, rigid, hose-like bowel with thick edematous mesentery, to a large inflammatory mass covered with a layer of fibrinopurulent exudate.

*From Harper Hospital, Detroit.

TABLE II. SYMPTOMS AND SIGNS

Symptoms and Signs	Resected Cases	Medically Treated Cases
Abdominal pain	100%	100%
Abdominal pain crampy in character	93	77
Diarrhea	35	33
Constipation	50	44
Alternating constipation and diarrhea	10	11
Normal bowel movement	5	11
Vomiting	50	33
Weight loss	91	33
Emaciated appearance	52	11
Tenderness	100	100
Abdominal mass	77	0
Visible peristalsis	5	11
Fever (100° or over)	64	33
Anemia	65	14
Leukocytosis	43	22
Fistula	18	0

Three of the last type of cases had fistulæ present. When the cecum was involved, the thickening of the bowel wall was greatest at the ileocecal valve. The disease, when involving the cecum and ascending colon, showed more hyperplasia than at other locations, and the differentiation from carcinoma was difficult. The one case involving the left colon was characterized by extensive thickening of the bowel wall and mesentery. The lumen of the involved segment was usually constricted, the mucosa edematous and distorted, and often ulcerated.

Microscopically, the thickening is found due partly to muscular hypertrophy and partly to varying degrees of chronic non-specific granulation tissue in the submucosa, muscularis, and subserosa. This granulation tissue contains nodules of fibroblasts, histiocytes, and often foreign body giant cells of the Langhans type. These may be densely grouped as to suggest tubercles and lead to confusion with tuberculosis. The irregular ulcerations are lined with similar granulation tissue infiltrated with leukocytes. The rest of the mucosa may have zones of atrophy and polypoid hyperplasia.

Several of our cases were first diagnosed as hyperplastic tuberculosis, but when the pathological changes associated with regional enterocolitis became a common and familiar picture, the diagnosis was evident.

Symptoms and Signs

The symptoms vary from mild abdominal pain to severe colic, and the appearance of the patient from health to the most striking emaciation. Crohn has described four clinical types:

1. Signs of acute intra-abdominal inflammation (resembling acute appendicitis).
2. Symptoms of ulcerative enteritis (diarrhea).
3. Stenotic phase (with symptoms of subacute incomplete intestinal obstruction, violent cramps, visible peristalsis, mass in lower right quadrant).
4. Persistent fistula.

In analyzing the symptoms in our patients, we thought it worth while to divide the cases into those that were far enough advanced to require resection (twenty-one patients) and those in whom resection was not performed.

It will be noted in Table II that all patients had abdominal pain and abdominal tenderness. Most of the resected cases had crampy abdominal pain, as did a high percentage of the non-resected cases. We consider the presence of crampy abdominal pain one of the most significant features of the history. The crampy pain is usually referred to the umbilical region and sometimes, depending on the degree of obstruction, is very severe in character. The presence of diarrhea unaccompanied by blood or pus in the stools is also suggestive of this condition, although the disease occurs often in the presence of normal bowel movement or even constipation. Weight loss, emaciated appearance, mass and visible peristalsis all indicate an advanced stage of the disease.

Differential Diagnosis

Fourteen (47 per cent) of our cases were originally operated upon with a preoperative diagnosis of acute or subacute appendicitis. The appendix was removed in eleven cases and the diseased bowel was resected in three cases.

An analysis of the symptoms in this group

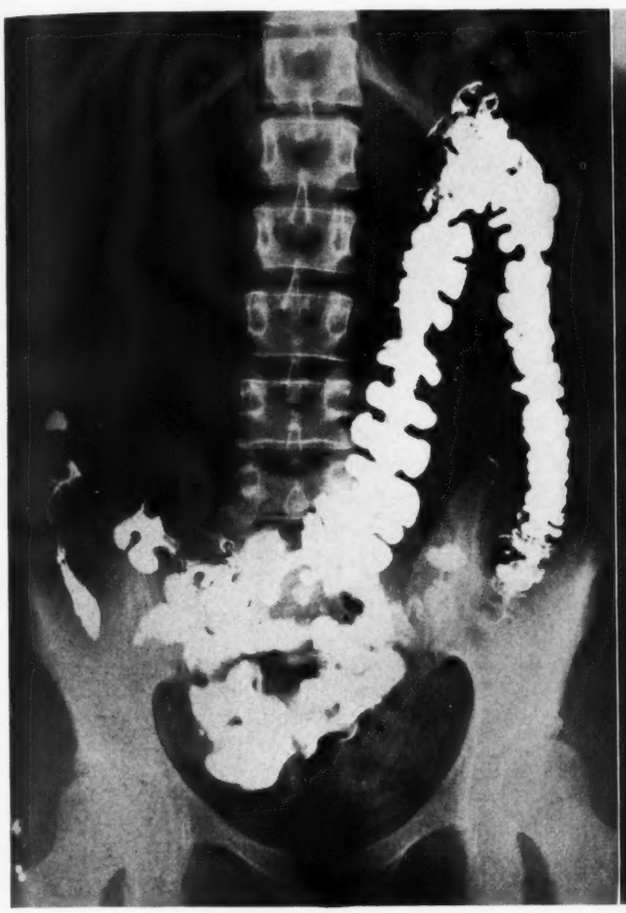

Fig. 1 (*a*). Four-hour roentgenogram showing marked irritability of terminal ileum with rapid passage of the barium through this segment of the bowel. (This patient had previously had an appendectomy with relief of symptoms.)

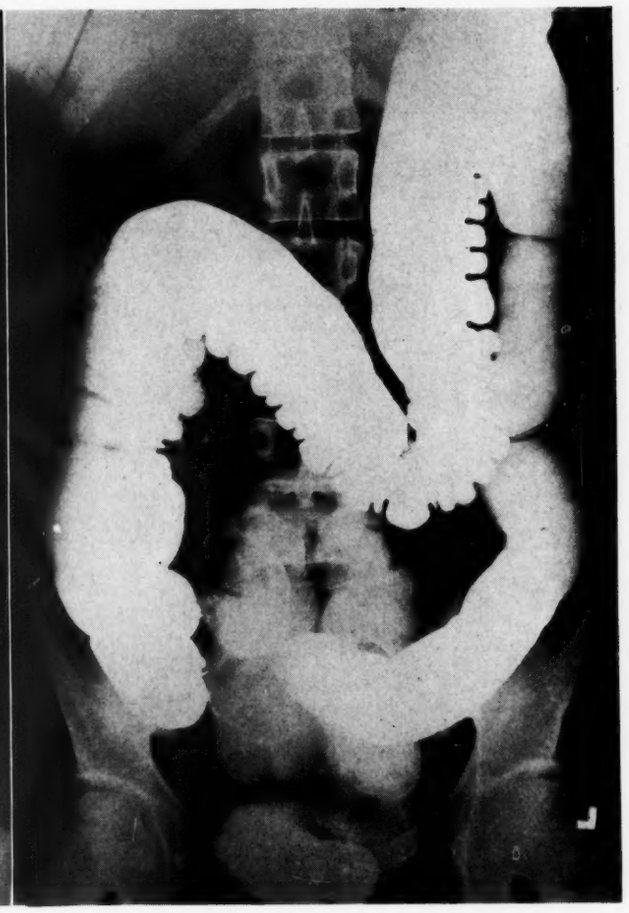

Fig. 1 (*b*). Barium enema study showing involvement of ileum just proximal to ileocecal valve with some early involvement of cecum. (Chest examination of this patient revealed no tuberculosis.)

show them to be indistinguishable from those of acute appendicitis. All patients complained of abdominal pain, most cases had nausea, vomiting, tenderness. A mass and diarrhea were present in one case and a history of previous diarrhea was given in another, both of which are by no means rare in appendicitis.

There were no button-hole incisions made in any of the cases, otherwise the true nature of the disease might have been overlooked. This is another argument in favor of an adequate incision when operating for appendicitis, as one might easily miss not only regional enterocolitis but numerous other conditions, such as Meckel's diverticulum, mesenteric lymphadenitis and pelvic disease.

The disease must also be differentiated from non-specific ulcerative colitis, intestinal tuberculosis, neoplasms of the large and small bowel and other organic and functional conditions causing diarrhea. In spite of careful study of the patient, laparotomy and pathological examination are often necessary to differentiate regional enterocolitis from other conditions which simulate it in many details.

Roentgenologic Observations

While the clinical impressions and symptomatology may suggest the diagnosis of enterocolitis, its diagnosis pre-operatively can only be established by roentgen studies, and then only if a careful study is made with particular attention directed to the small intestine and the region of the ileocecal valve. Sproull[11] has called attention to the fact that in the past years the roentgen study of the small bowel has been neglected. However, with the studies of Pendergrass,[9,10] Golden,[5] and others, there has been a marked revival of interest in the normal as well as in the pathological appearance of the small bowel pattern.

In the presence of cramplike abdominal pain, the first method of study should be by means of

Fig. 2. Four-hour roentgenogram showing early lesion in terminal ileum with narrowing of lumen and irritability of small intestine. (Limited lesions such as this may be easily overlooked.)

a barium enema. By this study any obstructing lesion of the large bowel can be eliminated as the cause of pain and often the ileocecal valve is incompetent and the terminal ileal loops may be filled quite easily with the barium enema, and if the terminal ileum is involved the diagnosis is established and no further study is needed. Often in these cases with extensive involvement of the small bowel there may be partial obstruction, and barium given by mouth may complicate the clinical picture by transforming a partial obstruction into a complete one. If, however, a diagnosis cannot be established by means of the barium enema, small amounts of barium and water may be given or a Levine tube may be passed into the duodenum and small amounts of barium suspended in water can be introduced into the intestine and one-half or hourly studies made in order to watch the progress of the meal through the small intestine, making note of any abnormality in the pattern, size of the lumen and distribution of the small intestine within the abdominal cavity.

The earliest changes which may be recognized in the roentgen study are those in the normal mucosal pattern associated with an abnormal irritability of the involved portion of the intestine, causing the barium to pass quite rapidly through that portion of the intestine (Figs. 1*a*, 1*b* and Fig. 2), so it is of considerable importance that great attention be paid to the motility of the meal. Often the localized hypermotility and the slight but definite change in the intestinal mucosa are the only clues to the positive diagnosis. In the more advanced cases, where the involvement is more extensive and the lumen of the intestine is more encroached upon, there may be and usually is a delay in the passage of the barium meal through the involved areas of the intestine (Fig. 3*a*), and the characteristic rigid lumen with the cord-like appearance that has been called attention to by Crane[2] and by Kantor[7] (Fig. 3*b*). As might be expected, the disease may not be continuous in its involvement of a given portion of the bowel, but normal bowel pattern may be interspersed.

In addition to the narrowing of the ileum, there is obliteration or change in the normal mucosal markings and at times a polypoid appearance of the mucosa of the bowel may be noted, and often the ulcerations in the ileum may be so extensive and acute as to cause an extreme hypermotility of the meal. As has been pointed out, with such an involvement of the ileum where the ileum is narrowed, one might expect dilatation of the intestine proximal to the involved area. This condition, however, does not usually occur as the small intestine proximal to the involved area may be of normal size, and when the cecum is involved, in addition to the terminal ileum, the cecum is often constricted and somewhat irregular in outline, the cecum assuming a more or less conical shape in relation to the ascending colon, and there is often an absence of the haustral markings.

When the colon itself is extensively involved it also shows constriction with mucosal irregularity, and the colon is contracted (Figs 4*a* and 4*b*). The ulcerative process in the colon is manifested roentgenologically by spasm, irritability and localized hypermotility of the involved segment of the bowel so that it retains very little barium either when the barium is given by mouth or enema studies are made. In such cases as these, the roentgen findings suggest those of a tuberculous enterocolitis and this is not unexpected in view of the similarity of the gross pathologic lesions in these two conditions.

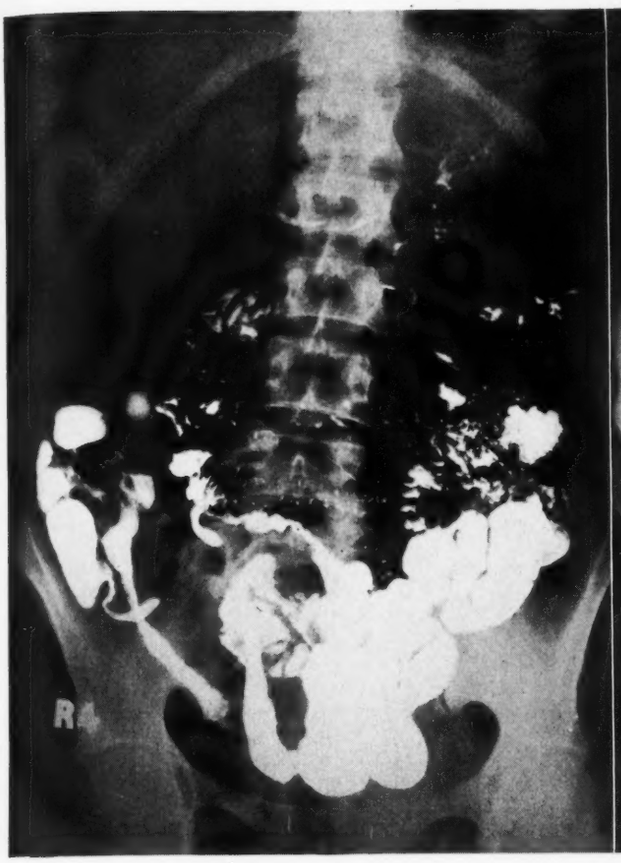

Fig. 3 (*a*). Four-hour roentgenogram. Note the narrowed ileal loops with the delay in passage of barium through the small intestine and the absence of dilatation of the loop proximal to the diseased areas.

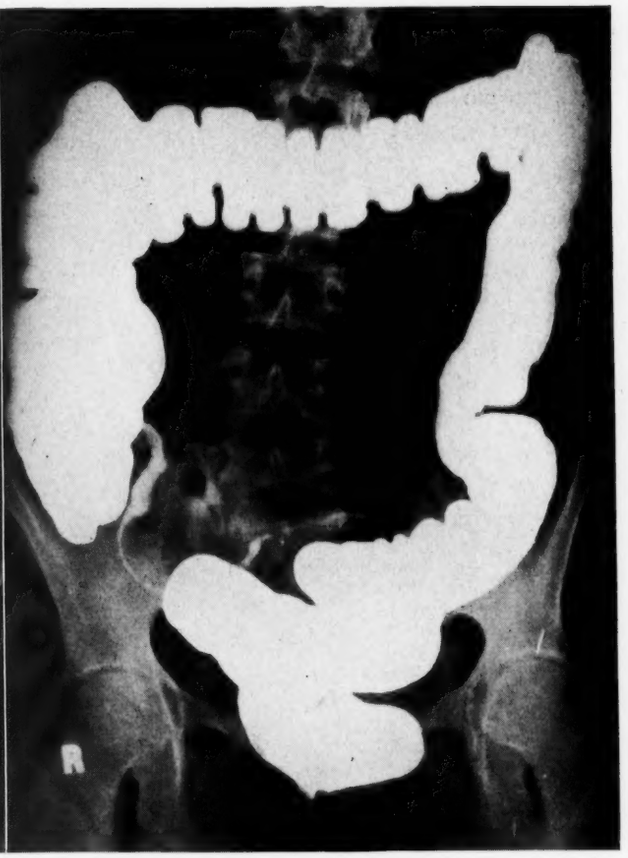

Fig. 3 (*b*). Barium enema study revealing a patent ileocecal valve and a narrow rigid lumen of terminal ileum with the characteristic cordlike appearance.

The jejunum itself is rarely involved, though in one of our cases there was involvement of the jejunum, which exhibited the same characteristic changes as are observed in the ileum, the lumen being quite irregularly narrowed and the normal mucosal pattern completely replaced with polypoid like excrescences.

In those cases presenting themselves with external abdominal fistulæ, Jellen[6] has suggested a very helpful diagnostic procedure in that if the patient is given indigo-carmine by mouth one may readily determine whether or not the tract communicates with the lumen of the intestine, and if it does, the sinus tract may be injected with lipiodol under roentgenoscopic control in order to note its extent and direction. Jellen has noted the difficulty of demonstrating internal fistulæ by the barium meal or enema, and he has called attention to a very important diagnostic point, namely that the presence of ileosigmoidal fistulæ in young adults should lead one to suspect a primary granuloma of the ileum rather than cancer of the sigmoid.

While the roentgen picture of terminal ileitis may be characteristic of the disease, it is not pathognomonic as has been pointed out by Kantor[7] and others; however, in the presence of an involvement of this type without roentgen evidence of tuberculous involvement of the lungs, one may be reasonably certain that the changes seen in the intestine are due to regional ileitis rather than to tuberculous enteritis which it simulates to such a marked degree, though occasionally tuberculous enteritis may occur without any associated pulmonary involvement.

Resected Cases

Table III lists data on resection operations performed on twenty-one patients. The original operation consisted of a one-stage resection in four patients, a two-stage resection in nine patients and a Mikulicz type of resection in eight patients. There were three recurrences (14 per cent) following these twenty-one resections, necessitating a second resection, which emphasizes the importance of searching for skip areas above

the main area involved, and resecting far enough above the diseased area.

All patients who had resection of the diseased area at the original operation recovered from the operative procedure. The operations were in general not difficult to perform, nor was the intermediate postoperative course stormy. The interval between the anastomosis and resection in most of the two-stage cases ranged from eleven to forty days.

Our patients have been followed for one to thirteen years to determine the end results which are shown in Table IV. All the patients treated by one of us (L.B.A.) are alive, demonstrating that the prognosis is somewhat dependent on acquaintance with the disease.

We have no patients with a remaining blind loop. Our judgment here is confirmed in the experiences of Brown and Donald,[1] who deal with the problem of whether or not to delay resection, after a preliminary "short circuit" when the patient is in apparent good health. Their recommendation is not to delay resection because of possible exacerbation of the disease.

TABLE III. RESECTED CASES (24 RESECTIONS ON 21 PATIENTS)

Type of Resection	Number Patients	End Result	Duration of Followup
			Years
One-stage primary ileocolostomy	4	3 well, no symptoms 1 Recurrence	2½, 2½, 2½ 2**
Two-stage ileocolostomy first, resection of ileum and right colon second	7	3 well, no symptoms 2 well except moderate diarrhea at times 2 Recurrence	13, 3, 1 6½, 3 1½**, 1**
Resection and ileostomy first, ileocolostomy second	1	1 well, no symptoms	3½
Ileostomy first, resection and ileocolostomy, second	1	1 well, small fistula	2¾
Multiple-stage Mikulicz resection	8	7 well, no symptoms 1 well except moderate diarrhea at times	9, 5, 4½, 3 2¼, 2, 2 2¼
OPERATIONS ON RECURRENT CASES	3		
Two-stage operation, ileocolostomy first Resection of ileum and colon second		1 well, no symptoms	5¾
Ileocolostomy		1 well, except moderate diarrhea at times	1½
Ileocolostomy		1 died of peritonitis postoperatively	

**Time between first and second operations.

TABLE IV. SUMMARY OF END RESULTS IN RESECTED PATIENTS

Well	14
Well, but tiny fistula	1
Well except for moderate diarrhea	5
Died of peritonitis after second resection	1

Indications for Resection

When a case is diagnosed by roentgen ray or laparotomy in the early stages of the disease and conservative treatment is deemed advisable, it should be kept under careful clinical and roentgenographic observation. If the symptoms do not abate under medical management and if

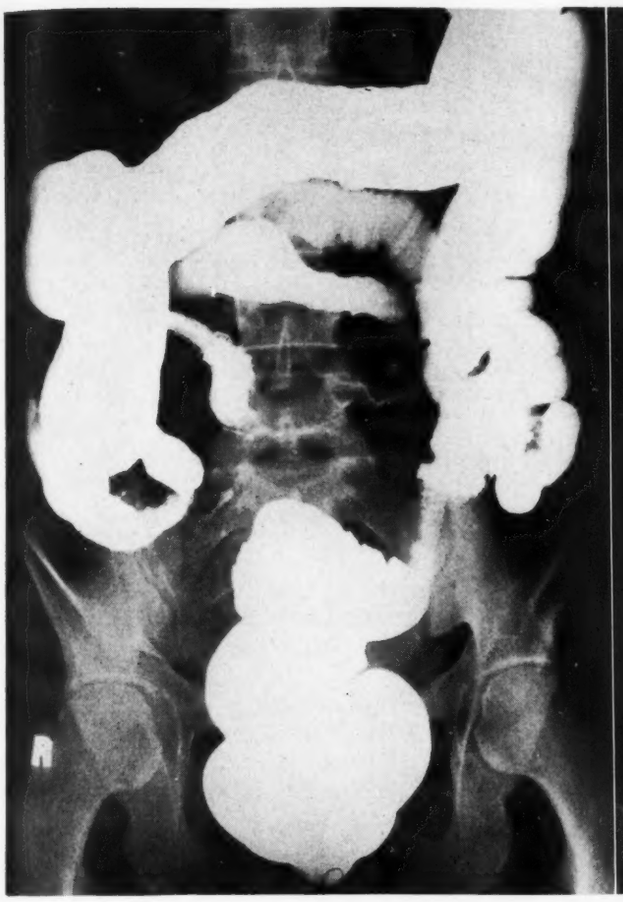

Fig. 4 *(a)*. Barium enema study showing extensive involvement of terminal ileum, cecum, ascending and first part of transverse colon.

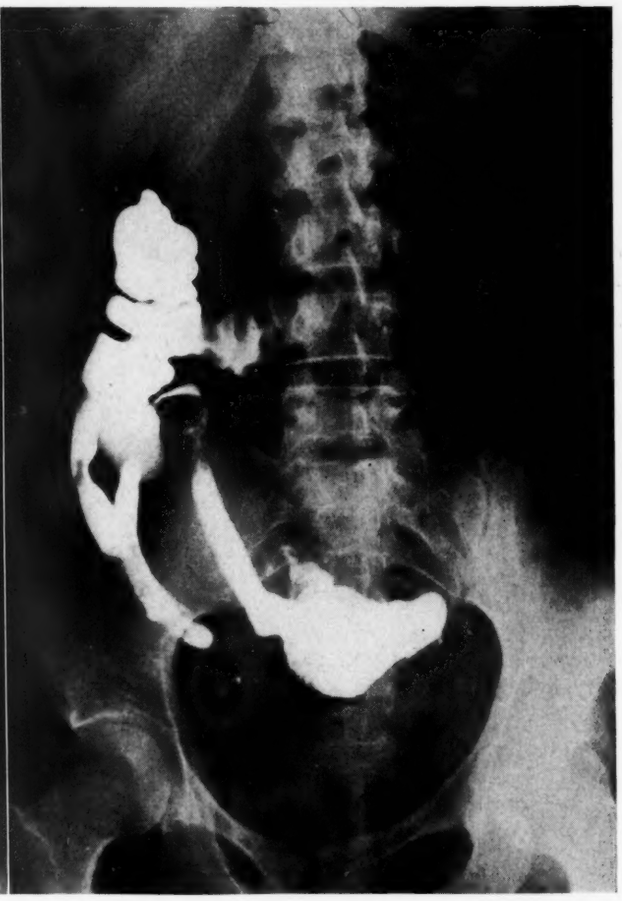

Fig. 4 (*b*). Examination after expulsion of barium enema revealing characteristic cordlike appearance of terminal ileum and the narrow contracted cecum, ascending, and proximal portion of transverse colon.

there is evidence showing the disease is extending, such as sepsis, increasing anemia and weight loss, and partial obstruction, surgical intervention should be advised. The presence of a mass, abscess or fistula indicate surgery.

We feel that all cases of the disease except the mild early type are surgical.

Type of Operation

We agree with Crohn[3] that the ideal type of operation for the cure of this disease consists of a two-stage procedure: the first stage, an anastomosis between the normal ileum proximal to the lesion, and the transverse colon, with transection of the ileum to prevent spread of the disease past the anastomosis; the second stage, resection of the ileum and right side of the colon. The merit of this type of operation is emphasized by the statistics of Mayo and Judd,[8] their series showing a mortality of three per cent for this two-stage procedure as compared to a twenty-two per cent mortality for the one-stage operation.

A multiple-stage Mikulicz resection has been utilized in our series with comparable success. We feel that this type of operation is especially indicated in the acute fulminating type of nonspecific ileitis and colitis, where there is an extensive exudate over the diseased loop of bowel with a possibility of impending perforation. It is also adaptable for some cases complicated by fistula or localized pockets of pus, where it is thought that too much absorption might occur between the stages of a two-stage operation.

Cases with Abscess or Fistula

Three cases were operated on for acute appendicitis, the appendix removed, the disease not recognized, fistula resulted and they were later resected. Appendectomy is strongly advised against when there is cecal involvement, due to the probability of a resulting fistula.

If the patient is in the acute fulminating stage, the appendix should not be removed.

If the patient is in an early or quiescent stage and there is no cecal involvement, it is advisable to remove the appendix. If in the subsequent course of the disease the patient has a recurrence of abdominal pain one does not have to worry about a perforated appendix.

One of our patients presented herself with a well-formed pelvic abscess. The abscess was drained, and at a subsequent operation the diseased intestine was resected with cure.

Preparation and After-care

The preparation and after-care of patients operated on for this disease consist of the same routine as followed in any type of bowel resection, namely, maintenance of the fluid and chemical balance, free use of blood transfusions, oxygen therapy, suction decompression with Levine or Miller-Abbott tube, and the sulfonamide group drugs.

End Results in Non-resected Cases

The ten patients who were not resected are tabulated in Table V.

TABLE V. END RESULTS IN NON-RESECTED CASES.

No. Pts.	Method of Diagnosis	End Result	Roentgen Check Since Operation	Duration of Follow-up Years
1	Laparotomy (plus biopsy of ileum)	1 Died on third postoperative day. (Patient 1)		
5	Laparotomy (plus appendectomy)	1 Died of intestinal obstruction 4 mos. after operation. (Patient 2)		
		2 Well (Patients 3 and 4)	One has slight rigidity of terminal ileal segments	2
		1 Mild recurrence 5 yrs. after append'y. Well for past 1½ yrs. (Patient 5)	Negative g.i. roentgen study	6½
		1 Recurrence after 10 yrs. with severe cramps, recurrence lasted 6 mos. Well for past year except moderate diarrhea. (Patient 6)	Spasticity and irritability of jejunal and ileal loops	11½
1	Laparotomy (plus biopsy of mesenteric gland)	1 Well except moderate diarrhea at times. (Patient 7)	Irregularity in calibre of upper segments of jejunum and ileum. Marked improvement from pre-operative roentgen study	2
3	Roentgen examination	1 Well (Patient 8)		1
		2 Feel well except for some gas distress. No diarrhea. (Patients 9 and 10)		1¾
				3

Patient 1 was operated on for a pelvic mass the origin of which was pre-operatively thought to be tubal or ovarian. During the exploration a thick leathery terminal ileum was found. Some adhesions were freed which caused exudation of a small amount of pus. Biopsy of terminal ileum was performed. Death from peritonitis occurred on the third postoperative day.

In patient 2, an acute regional ileitis was discovered at operation in December, 1937. Appendectomy was performed. The patient was rehospitalized in January, 1938, at which time roentgen examination showed involvement of ileum and colon. The patient was rehospitalized again April 8, 1938, with admission diagnosis of partial intestinal obstruction and was treated conservatively with Levine tube, et cetera. Death occurred April 20, no operation, no autopsy. This patient should have been operated on again as there was ample warning of obstruction.

Patients 3, 4, 5 and 6 had laparotomy for what was taken to be acute appendicitis and the diagnosis of ileitis was made by inspection. Conservative treatment

was decided upon as the lesion consisted only of thickness and doughiness, inflammation without exudate, and no evidence of impending obstruction. Appendectomy was performed without subsequent fistula formation. All these patients are well although one had a mild flare-up five years after appendectomy, and the other a severe flare-up ten years after appendectomy.

Patient 7 had roentgen findings of involvement of the jejunum and ileum. At operation two years ago extensive involvement of the jejunum and ileum were found. Appendectomy was not performed but a mesenteric gland was removed. The process was too extensive for resection. A single deep roentgen treatment was given but the patient refused further radiotherapy on account of nausea. There has been marked improvement in her clinical status with no medication. She is well except mild diarrhea occurs if she does not select her food carefully. Roentgenologic check shows marked improvement in roentgen appearance of the bowel. The results of non-surgical management are particularly striking here, as this patient had the most extensive involvement of any in our series.

Patients 8, 9 and 10 presented themselves with the symptoms of subacute or chronic appendicitis. Roentgen examination showed ileitis of mild degree, with such findings as spastic and ribbon-like ileum, disturbance in mucosal pattern of terminal ileum and coarse mucosal folds in colon. None had obstructive signs or the string sign. All these patients are well although two complain of some gas distress from time to time.

Of the eight non-resected patients who are alive, three have no symptoms; one had exacerbation of symptoms but is now well, and four are reasonably well. They lead a normal life but have to be careful about roughage in their food or they suffer from gas distress or mild diarrhea.

If there are no complications, these patients should be treated along the same lines that one treats chronic ulcerative colitis: rest, high protein, high vitamin, high calorie diet, supplemented with vitamins, especially vitamin B by mouth or parenterally, and liver extract.

Summary

1. Thirty-one cases of regional enterocolitis are reported and discussed. The location, age incidence, symptoms and signs, non-resected cases, resected cases, follow-up periods and end results, are shown in tabular form.

2. The most frequent symptom encountered was crampy abdominal pain located at the navel or in the lower right quadrant. Other symptoms suggestive of the disease are diarrhea without blood or pus in stools, weight loss and emaciation, fever, mass in lower abdomen and fistula formation.

3. The earliest roentgen signs of regional enterocolitis are abnormal irritability of the involved portion of intestine accompanied by an abnormal mucosal pattern; in the later stages, there is a narrow rigid lumen with change in the mucosal pattern, at times accompanied by a polypoid appearance of the mucosa.

4. Roentgen ray studies of the gastro-intestinal tract offers not only a means of establishing the diagnosis but also gives a fair idea of the extent of the process.

5. Of the ten non-resected cases, seven were diagnosed by laparotomy and three by roentgenographic examination. Most of them were considered as early cases and conservative treatment was followed. Two patients died, one following biopsy, and the other due to rapid extension of the disease (obstruction). Both deaths occurred because of errors of surgical judgment; resection should have been done. Of the remaining eight patients, 50 per cent are well and 50 per cent have mild symptoms.

6. Early regional enterocolitis is a medical disease, and the cases should be followed with careful dietary supervision and frequent observation.

7. Extension of the disease is an indication for surgical intervention as are complications such as obstruction, abscess and fistula formation.

8. Twenty-one patients underwent the following types of resection: one-stage, four patients; two-stage, nine patients; multiple-stage (Mikulicz) eight patients. Results of primary operation resulted in cure of 67 per cent, great improvement in 19 per cent and recurrence in 14 per cent. In the three cases with recurrence, a second resection was performed, one of which resulted in the only death from operation in our series of resected cases.

9. Radical resection is the treatment of choice for the advanced case, preferably in stages.

10. Removal of the appendix in the early cases is not harmful unless the disease involves the cecum. Removal of the appendix in the advanced

or fulminating cases often results in abscess or fistula.

11. It will be seen that a thorough knowledge of enterocolitis may prevent prolonged illness, multiple operations and even death.

We are indebted to Drs. W. D. Barrett, C. D. Benson, E. V. Johnston, G. Kamperman, J. D. Mabley, G. C. Penberthy, H. C. Saltzstein and C. L. Tomsu for the use of nine of the cases reported.

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Glomus Tumor, or Glomangioma

A Case Report

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Menominee, Michigan

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The glomus tumor is a small, sharply circumscribed lesion involving the cutaneous surfaces of the digits. It is characterized by intense, knife-like, radiating pain caused by trauma or temperature changes.

The rarity of glomus tumor is demonstrated by the fact that in a series of 74,000 surgical specimens, only two cases of glomus tumor were found.

Treatment for this condition is complete surgical removal. X-ray and radium as curative measures have been found useless.

■ The rarity of glomus tumor can be appreciated when careful search of medical literature fails to reveal it defined and described before 1920. Barré, in 1920, suggested its probable histology and demonstrated that it could be removed satisfactorily by surgery. In 1924, Masson exhaustively described the histogenesis of this tumor and demonstrated its constant pathologic appearance.

Jirka and Scudari, in 1936, reported a case which they record as the seventeenth authentic case to be recorded in literature. Furthermore, it is significant that in their series of 74,000 surgical specimens (unselected cases) examined in the Cook County Hospital, only two cases of glomus tumor were encountered. Up to the present time, Jaeger and Kingry estimate that only one hundred fifty cases of this tumor have been reported.

The tumor has been defined simply and completely by Bailey as follows:

"The glomus tumor may be considered an overgrowth of a specific arterio-venous anastomosis and the neurones terminating in it."

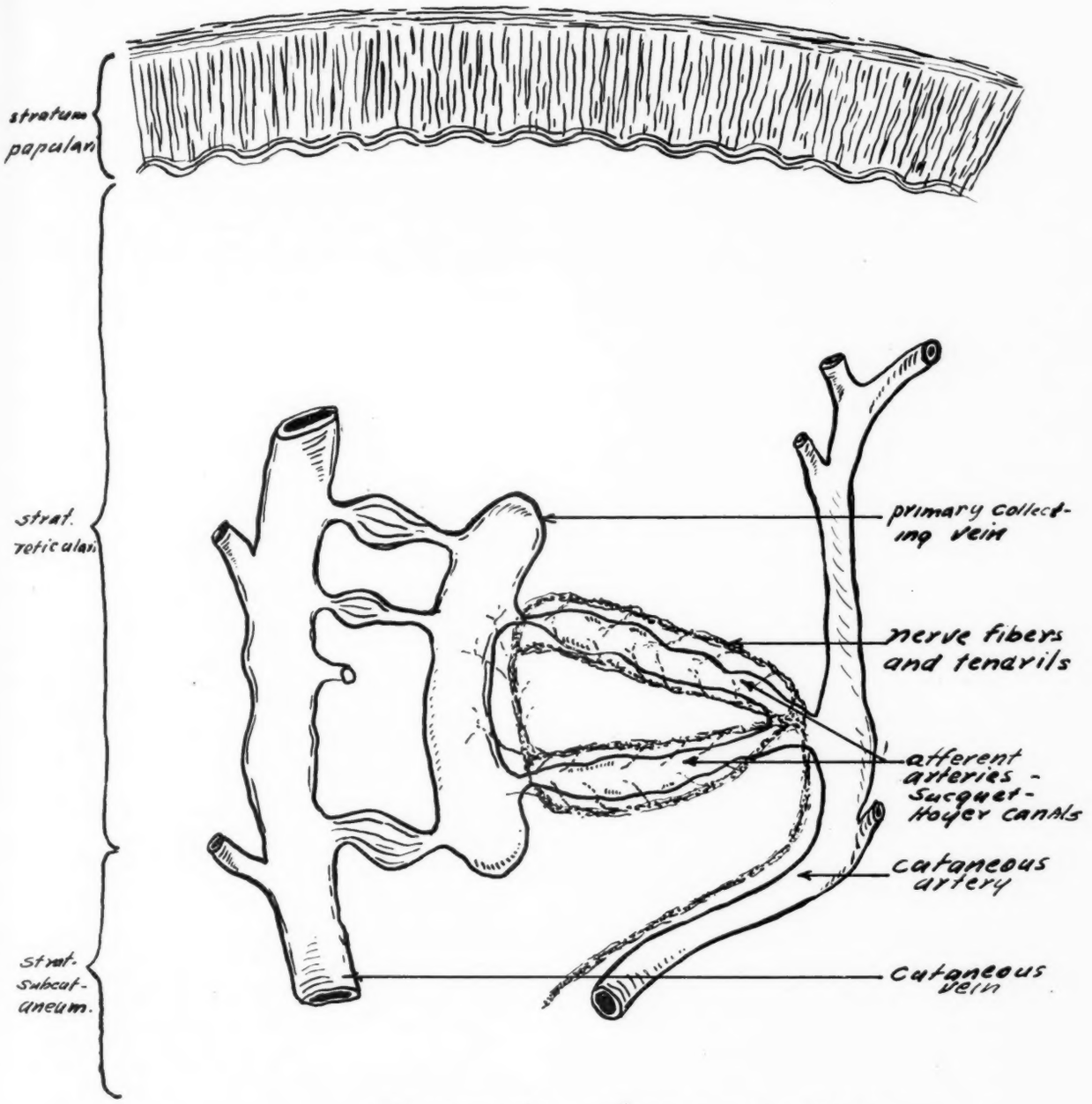
Etiology of this tumor is not known. However, forty per cent of these tumors occur following trauma. Eighty to ninety per cent reported were on the fingers or toes, which, by location, are subjected to trauma or repeated "pressure insults." It is the opinion of the author that we therefore must include trauma as a definite etiologic factor.

The histologic picture of the tumor is constant and characteristic. In the illustration (taken from a drawing by Popoff) the elements of the normal glomus are schematically represented.

Pathologically and microscopically, the glomus tumor is characterized by "hyperplasia of its elements and a new formation of Sucquet-Hoyer canals which are not separately and purposely aligned with the afferent artery and collecting vein, and the mantle of epithelioid cells is not uniform" (Weidman and Wise). The pathologic picture then shows all phases of hyperplasia of the essential elements of the tumor and one element alone may be preponderant in its overgrowth, or a combination of two or three elements may predominate in the hyperplasia. A third possibility is that the entire structure may be involved in hyperplasia.

The signs and symptoms of glomus tumor are nearly always constant and are here mentioned in the order of their importance.

Objectively, the most common site where these tumors are encountered is the subungual region



Relationship of normal glomus to surrounding structures

(Copied from an original drawing by Popoff.)

of the fingers or toes, or less frequently, away from the nail and on the distal regions of the fingers or toes. Their appearance is usually that of an annular or oval lesion, pigmented, either purple, blue, or red, and usually about three by five mm. in diameter. They lie just beneath the nail or just beneath the surface of the skin, and they may be seen occasionally to blanche on pressure. Localized sweating of the immediately adjacent area may be encountered, and the affected digit may be atrophied as a result of disuse.

Subjectively, the tumor is characterized by intense pain either from the slightest trauma, or from changes in temperature. The character of the pain is intense, knife-like, and most generally radiates up the arm or leg from the tumor or "trigger zone." X-ray studies are not helpful in the diagnosis of this condition. Infrequent reports of bone erosion due to pressure are encountered in the literature, but these are by no means constant. The diagnosis must be based on the appearance and location of the tumor as above described and the history of characteristic pain.

The differential diagnosis includes:

1. Small foreign bodies producing pain
2. Subungual exostosis
3. Subungual clavus
4. Subungual papilloma
5. Subungual fibroma
6. Subungual enchondroma
7. Subungual angiokeratoma
8. Neurinoma
9. Hemangioma
10. Endothelioma
11. Angiosarcoma
12. Ewing's tumor
13. Round cell sarcoma
14. Boeck's sarcoid
15. Sutton's tumor
16. Chondrosarcoma
17. Melanoblastoma
18. Carcinoma

The prognosis of this tumor is good. It has never been found to be truly malignant in the sense that its overgrowth extends either by contiguity or metastasis, and recurrence and pain are unknown after complete surgical removal.

As suggested above, the treatment is complete surgical removal. X-ray and radium have been tried as curative measures, but have been found useless. Simple excision wide about the tumor or painful site is sufficient to render immediate cure and relief.

Case Report

C. E. H., white, female, aged thirty-eight, came under observation in the fall of 1941 complaining of pain in the index finger of the left hand.

As the patient was being removed from a delivery room in 1928, she struck the index finger of the left hand against a door. Pain was immediate and lasted about three weeks and then partially subsided. She states that occasionally there was a slight throbbing pain in the finger which came on without trauma.

Four years later, in 1932, the finger became painful to the slightest trauma or temperature change. These stimuli caused pain locally with radiation up the flexor surface of the arm as high as the elbow. Sweating occurred after trauma or temperature change. The sweating was not encountered in the other fingers of the left hand, nor was it seen over the course of the radiated pain. Objectively, there was no lesion discernible, but there was a point on the middle surface of the terminal phalanx of the index finger which, when in any way traumatized, caused intense radiating pain. This "trigger zone" was three by four mm. in diameter.

Prior to coming to the office, the patient, in 1938, had consulted a physician who advised her to have her teeth x-rayed. Following this, six teeth were removed. Pain in the left index finger still persisted. In 1939 she consulted another physician who taped the finger. She was not advised of the nature of the lesion. This physician later advised removal of the distal end of the affected phalanx of the finger to relieve pain. Again, in 1939, another physician was consulted, who also taped the finger and also wanted to remove the affected phalanx. X-rays at that time were taken and this physician advised the patient that "the bone of this finger was honeycombed as a result of infection," presumably from the teeth. The patient refused to have the distal end of her finger removed. Again, three teeth were extracted, and again no relief was obtained from pain.

Physical examination was negative with the exception of the index finger of the left hand, and here no visible lesion was encountered, but as above mentioned, there was a painful point over the medial surface of the index finger of the left hand.

Laboratory procedures, including Kahn test for syphilis, urinalysis, blood count, and x-ray of the affected finger were entirely negative.

The patient was advised to have the painful site removed by surgery under local anesthesia.

Accordingly, on December 12, 1941, the patient was operated on at the Marinette General Hospital. A local anesthesia of 2 per cent novocaine was used, and an elliptical incision was made widely about the painful point and down to the periosteum, and this segment of tissue was removed. The skin was closed by interrupted sutures. Convalescence was uneventful, and since operation, there has been no pain or discomfort in the previously painful area.

The specimen was sent to the Marquette University Department of Pathology, from which the following report was received: "The presence of abundant nerve elements, collections of glomus-like cells around some of the venioles, and one fairly large blood space confirm the clinical diagnosis of glomus tumor."

Unfortunately, the order for microphotograph of the specimen was not received by the pathologist, and the specimen was examined by the freezing technique; consquently, a microphotograph cannot be included in this report.

Summary

A case of glomus tumor of the finger is reported. The case is typical in regard to history and pathologic findings, but atypical in that the tumor presented no external appearance characteristic of its nature. A satisfactory result by surgical removal was obtained.

Conclusions

Small, sharply circumscribed, and intensely painful lesions involving the cutaneous surfaces of the digits should suggest the presence of glomus tumor and should be removed surgically.

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No vision and we perish; no ideal and we are lost.
Our hearts must ever cherish some faith at any cost.
A hope, a dream to cling to, some rainbow in the sky,
Some melody to sing to, some service that is high.

—Exchange.

Evaluation of Rectal Examinations*

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A rectal examination is performed easily and quickly. The pain previously experienced during this examination has been minimized by the various anesthetic, means for aiding an operator who studies the anatomy of the rectum and the anal canal.

Reluctance on the part of the patient, especially females, that formerly existed is today almost nil. Can as much be said regarding physicians in making rectal examinations? The more the general practitioner performs rectal examinations, the greater the number of earlier diagnosed cases of cancer will be recorded. Much suffering will be avoided, and a greater number of lives will be saved by adequate surgery. Eighty per cent of all cancers of the rectum may be determined by a digital examination.

Even our present armamentarium, radical surgery, requires early diagnosis for a complete cure of cancer of the rectum. Much time and money is wasted when a physician omits a rectal examination.

■ THE purpose of this contribution is threefold:

1. To show the importance of more frequent rectal examinations.

2. To show that every physician has with him, at all times, the two necessary requisites to diagnose at least 75 per cent of all anorectal pathologic lesions.

3. To offer a method which has proven satisfactory in my thirty years' experience for making a rectal examination.

Importance of Frequent Rectal Examinations

Hirschman says:

"It has been been estimated that one patient out of every seven is suffering from some disease, the relief of which would be assisted, or entirely accomplished, by the treatment of pathological conditions discovered only upon a proctologic examination."

Gant says:

"Many individuals suffer from constipation, diarrhea, or other affection of the small intestine, colon, or

*Read before the Seventy-seventh Annual Meeting of the Michigan State Medical Society at Grand Rapids, Michigan, September 25, 1942.

rectum who unnecessarily become chronic invalids because their early symptoms go unrecognized or are considered unimportant."

Mummery states that all too frequent, patients make their own diagnosis of "piles" and have prescribed for them, suppositories and rectal ointments for long periods, before a rectal examination is done.

It is surprising to find, even today, doctors prescribing the much advertised suppositories for any rectal complaint. Carcinoma of the rectum, whether more frequent or more readily diagnosed, is rapidly climbing the ladder of vital statistics, and should be diagnosed very early, if our present armamentarium for the eradication of an intra-cavity neoplasm can be of help.

If this contribution stimulates the rectal examination of just one sufferer from carcinoma, with a resulting successful eradication, then this message will not have been in vain.

Carcinoma of the rectum is a terrible condition, especially when we see it has no respect for age or sex. If a neoplasm is found early, before migration of the neoplastic cells has started, we have surgery, radiation, radium and fulguration, as our means of cure. It is my hope the biochemist will offer more in the near future.

What then is an early case of carcinoma of the rectum?

It is that case which we diagnose soon enough to prevent the horrible results we are seeing.

Requisites for Diagnosis

Every physician is endowed with the two senses: The power to see, and the power to feel, but one must train himself to make a mental picture of the pathologic condition found, with the use of his fingers.

Approximately 75 per cent of all anorectal pathologic lesions may be diagnosed without the aid of the 'scopes. The remaining 25 per cent may be diagnosed with the aid of the anoscope, rectoscope, sigmoid and proctoscope, providing one has training in diagnosing the pathologic condition seen.

It seems unnecessary for doctors to carry around a complete case of instruments without having had the training necessary to interpret their findings. Allow me to show a report on one case which proves that a gun does not make a hunter.

I quote from a hospital chart:

November 2, 1940

"A twelve-inch sigmoidescope passed nine inches without interference beyond which point I was unable to pass the instrument. From mid-rectum to lower third of sigmoid mucous membrane is reddened, edematous, moth eaten in appearance and bleeds very freely. At the upper end of lower third of sigmoid, there is an acute angulation which prevents further passage of sigmoidoscope. There is a continuous flow of bright, red blood, at all times in the upper end of sigmoidoscope. I believe this condition to be an acute inflammatory lesion, either of the acute ulcerative type, or dysenteric in origin. It does not have typical appearance of either one, nor does a lack of temperature, and leukocyte count go with either of these pictured. However, I have never seen a mucous membrane of this type, nor seen described in the literature anything of similar appearance below a malignant lesion. However, I cannot positively rule out malignancy in upper sigmoid, or left colon. There is too much bleeding at this time, to take a specimen.

Advise: (1) Bacteriological studies. (2) Delay in surgery.

November 11, 1940

"Sigmoidoscopic Examination: The lower rectal mucosa is clear with no polyp, or inflammatory reactions. From upper rectum into sigmoid the mucosa is ulcerated, moth-eaten in appearance, and bleeds readily on the slightest trauma. This is definitely an acute ulcerative colitis. X-ray shows two filling defects in right colon."

It so happened that this was a case of avitaminosis. The patient, who was in a serious condition, made a rapid, uneventful recovery shortly after proper treatment.

I do not wish to appear critical when I report this case, because I find conditions which baffle myself, while making daily examinations. The proctologist today, is diagnosing hitherto unknown entities by careful examination of the bowel wall. It was not far back when cascara-stained mucosa of the rectum was labeled "melanoma."

Again, *"Lest We Forget,"* approximately 75 per cent of all anorectal pathologic change is diagnosed by the eyes and the hands.

Seeing is believing, so allow me to show a few slides, tabulating the pathologic conditions:

By Inspection (a)

1. Prolapsed internal hemorrhoids.
2. External thrombosis (so-called external thrombotic hemorrhoids).
3. Peri-anal excoriations.
4. Tumors.
5. Abcesses.
6. Anomalies.

7. Skin tags (postoperative).
8. Pilonidal sinus.
9. External opening of fistula.
10. Discharge of blood, if from the anus or rectum.
11. Skin lesions.
12. Rectovaginal fistula.
13. Scars in female perineum.
14. Loss of sphincter muscle.
15. Fissure and anal ulcer.
16. Base of filled crypt.
17. Pinworms.
18. Postoperative scars.
19. Contour of anal area.

Digital (b)

1. Spastic sphincter.
2. Anal ulcers.
3. Filled crypts.
4. Ulcerative crypts.
5. Hypertrophied papillae.
6. Adenoma.
7. Carcinoma.
8. Fistula opening—internal.
9. Submucous abscess.
10. Spasm of the pyriformis muscle.
11. Anomalies, fractures and dislocations of the coccyx.
12. Hemorrhoids, internal, thromboses or fibrous after injection.
13. Prostatic enlargement, or involvement.
14. Sphincter relaxed from spinal cord lesion.
15. Rectovaginal fistula.
16. Postoperative loss of sphincter muscle.
17. Stricture of the anus.
18. Stricture of the rectum.
19. Pelvic organs.
20. Redundant valves.
21. Redundancy of rectal mucosa.
22. Appendiceal abscess.
23. Postoperative pelvic abscesses.
24. Extrarectal tumors, lympho sarcoma, and metastatic tumors, endometriosis.
25. Intussusception.
26. Fecal impaction.

Anoscopic (c)

1. Internal hemorrhoids.
2. Inflamed crypts.
3. Hypertrophied papillae.
4. Tone and color of rectal mucosa.
5. Adenomas.
6. Carcinoma.
7. Blind fistula.
8. Submucous abscess.
9. Anal ulcer.
10. Stricture of anus and rectum.
11. Rectal ulcers.
12. Presence of mucous or blood.
13. Foreign bodies.

Sigmoidoscopic (d)

1. Tone and color of mucosa, beginning at point 3 inches up to 10 inches from the anus.
2. Stricture of rectum.
3. Rectal adenoma, pedicle or flat base.
4. Rectal and sigmoid carcinoma.
5. Lympho granuloma.
6. Bleeding of lymphatic areas in avitaminoses.
7. Dysentery, acute—chronic.
8. Enlarged valves, edematous.
9. Nematodes.
10. Ulcerations.
11. Blood vessels.
12. Spasticity of rectosigmoid.
13. Intussusception.

Summary

Inspection	18	
Digital	26	
Anoscopic	13—	(4) not by finger.
Sigmoidoscope	13—	(10) not by finger.

With fifty-six conditions accounted for, and fourteen conditions which must be diagnosed by scopes, therefore, we have the approximate figures of 75 per cent by use of hands and eyes, and 25 per cent by use of ano, and sigmoidoscope. Since figures do not lie, and good figures may be liars, I have purposely added the word "approximately." That there may be splitting of hairs regarding the pathologic condition noted is also admitted, but I must bring to your attention the great amount of good that may be done without the use of instruments by use of your eyes and your hands.

Were I to speak of abdominal examination again, the eyes and the hands are the first order before instruments, or roentgenology.

Rectal Examination

A rectal examination is performed easily and quickly. The pain previously experienced during this examination has been minimized by the various anesthetic means for aiding an operator who studies the anatomy of the rectum, and the anal canal.

Reluctance on the part of the patient, especially females, that formerly existed, is today almost nil. Can as much be said regarding physicians in making rectal examinations? The more the general practictioner performs rectal examinations, the greater the number of earlier diagnosed cases of cancer will be recorded. Much suffering will be avoided, and a greater number of lives will be saved by adequate surgery. *Eighty per cent* of all cancers of the rectum may be determined by a digital examination.

Rectal examination is essential for a complete physical examination. There are four steps in

making a rectal examination: Inspection, digital, anoscopic, and proctoscopic and sigmoidoscopic.

Inspection.—Performed with use of the eyes.

Digital.—By the use of the index, or little finger. Intelligent interpretation of the visual sense, and a mind picture made by tactile sens through the index finger will diagnose about 75 per cent of pathologic conditions found in and about the anus and rectum.

Anoscopic and Sigmoidoscopic.—Examinations are made by using an anoscope for the *anal canal* and lower *rectum*. The sigmoidoscopic examination brings into vision the middle, upper rectum and the sigmoid.

A rectal examination should be made with the patient in a position so that the operator, as well as the patient, is as comfortable as possible. Rectal examinations are not any harder than a nose and throat examination.

In my offices the following method is used. Hospital examinations are also carried out in the same manner:

The examining table is flat, covered by a sponge rubber pad, about 2.5 inches in thickness; this for comfort. Paper sheets, towels and tissues have many advantages over linen.

The patient is placed on the left side with both knees drawn toward the abdomen. The thighs are placed at a 45° angle with the body and the legs at a 45° angle with the thighs. This allows space for the necessary materials to be placed below the patient. A cover sheet placed over the patient before clothing is raised or opened.

Four paper towels, three or four soft tissues, a finger cot and lubricating ointment, are placed in the space below the buttocks. A piece of tissue is placed under the patient's hand, and on the right buttock, and the patient is instructed to draw upward with the hand flat on the buttock. Rectal cases are as a rule, very apprehensive, and a little reassurance at this point helps considerably.

At this time, I state to the patient that I shall tell him all the conditions found, regardless of what I find. Should he insist that I do not, I grant his wish, but the great majority of patients want to hear the results.

I can honestly state that many individuals have been made happy and have taken a new lease on life, especially those who have had experiences with cancer of the rectum in their immediate family, when I have informed them that I found no evidence of cancer.

It is not easy at times to inform patients point blank that they have a cancer, but I know this, that once the shock is over, the coöperation, willingness, and expressed confidence is far better than having that feeling that something is being withheld, or that the doctor is not able to diagnose the condition.

I cannot agree with those who whisper cancer; designate all growths as tumors. The people today are well informed regarding cancer. At times it is just as hard for the informer as for the informed. The hardest case in my experience was that of a young man, thirty-two years of age, a father of three children, who was sent with a note asking whether I could do something for that "hemorrhoid" which did not respond to treatment after considerable time. Six months later he died with metastasis in the lung.

This subject could be discussed from many angles, but I have seen but one woman aged fifty-two years, who gave up as it is said, and passed on. This might be called a blessing, as she had an inoperable carcinoma, with a frozen pelvis.

It is my procedure to state to the patient that should there be pain, to inform me and I will stop the examination. Should there be considerable pain, a drop of phenol may be placed on the skin about 1/2 inch behind the anal opening, and about 5 c.c. of 1 per cent novocaine in water may be injected into the subcutaneous tissue.

Press the needle on the spot made by the phenol, and instruct the patient to cough. The needle enters, and the anesthetic may be injected on both sides without removing the needle. Local anesthesia requires a few minutes to act, and the patient is instructed to take his hand from the buttock, for at least five minutes. We are then ready for the first step.

Inspection.—With the patient raising the right buttock, the operator can press on the left buttock and expose the anal region. This examination will reveal whether or not, the sphincter is spastic, whether there are protrusions from the anus, whether these are new breaks in the perianal skin, openings of fistula of pilonidal sinuses, whether there is discoloration, swelling, discharges or blood, excoriations, condylomata, or anal ulcers, skin tags. The anus may be opened to reveal prolapsed hemorrhoids, hypertrophied papillae, or polypoid growths. Instruct the patient to slide the hand forward; the vagina in the female and the scrotal area in the male may then be examined.

Digital.—With the finger cot on the right index, or little finger, place a loop of soft tissue

around the base of the examining finger. Pressure is made around the anus. This will reveal sensitive areas; or inflamed tissue beneath the skin. The examining finger is then placed against the external sphincter with the palm of the operator's hand facing back, and pressure is made toward the symphysis. The patient is then instructed to cough. The sphincter relaxes, and the finger enters the canal. Pointing the finger towards the sacrum, the anal canal is examined and the finger enters the rectum. As the finger goes through the anal canal, we feel for cord-like areas, or depressions.

It is well to keep pressure toward the anterior portion of the anus as a great majority of cases have an anal ulcer in the posterior commissure. The anal ulcer is one of the most frequent and painful conditions found.

As we pass through the canal, and feel cord-like structures, the swelling at times, will disappear. This is an emptying of a filled crypt, or possibly an anal duct or gland, brought to attention by Tucker and Helwig, and Hill in the *Transactions of the American Proctologic Society.*

We see many patients who receive considerable relief from this procedure. The finger is then passed along the anterior rectal wall, making a side-to-side movement. In the male the prostate is examined for size and texture. In the female the pelvic organs are felt for movability and size.

The rectal mucosa is examined for growths, or redundancy, submucous abscesses and swinging the finger towards the posterior rectal wall, the first valve may be felt. The coccyx and sacrum is then examined bimanually. Leading from either side of the sacrum, the pyriformis muscle may be examined. If the muscles are contracted, there is considerable pain elicited. Gentle massage of these muscles frequently relieves the patient of the so-called "low backache," or coccyxadynia. Frequently anal ulcer is found in cases of spasm of the pyriformis muscle, and healing of the ulcer brings relief.

Having examined the coccyx for old fracture, or dislocation, the finger is then brought down the posterior rectal wall, and into each sciatic notch. Anal ulcers and growths are felt as the finger comes down to the external sphincter. I have as yet been unable to make a positive diagnosis of internal hemorrhoids with a finger, except those thrombosed or fibrosed, but redundant rectal mucosa may be detected by instructing the patient to cough. This will force the rectal mucosa downward against the finger. This is also true for tumors.

It is surprising the amount of intra-abdominal pressure that is caused by a forceful cough. It is my opinion that this will aid as much as the position of squatting, or bending over a table in making a diagnosis of rectal tumors.

The finger is withdrawn slowly, making pressure against the anterior commissure. The tissue, and the finger cot are removed, placed into one of the paper towels and discarded.

Anoscopic.—I prefer a slotted anoscope, about 3.5 to 4 inches in length. The same procedure, as with the finger, is carried out. Coughing helps as much for this examination as for the digital. The patient is then instructed to lift a little more on the buttock, thereby relaxing the sphincter. The obturator is removed, and examination of the posterior commissure is made. The obturator is placed in the 'scope, and the instrument is rotated, so that the slot is on the right side.

This is continued on all four sides for ulcer, hemorrhoids, crypts, and tone and color of the mucosa, hypertrophied papilla, polyps. The anoscopic examination is completed, and the swabs and tissue are placed in paper towels and placed in receptacles beneath the table. The scope is then put in the basin for washing and sterilizing.

In examining for hemorrhoids, it is well to remember that the primary hemorrhoids on the right and left side are from the superior hemorrhoidal veins and pass into the submucosa about 3 to 3.5 inches from the external opening.

The primary hemorrhoid in the anterior commissure, is from anastomosis of the middle and inferior hemorrhoidal veins, and dips through into the submucosa at a lower level. Secondary hemorrhoids are from the middle and inferior hemorrhoidal veins. The plexus of veins so often seen at the anal opening are from branches of the middle and inferior vessels.

In removing primary hemorrhoids, it is well to place the sutures in the mucosa at different levels and thereby prevent a stricture of the rectum. Having completed the anoscopic examination, all materials are removed from the table.

A towel held by two small chains is then placed over the buttock, and the patient is then told to get on his knees on the table, placing the elbows on the pillow; a slight pat on the back will cause him to lower his back into the correct position.

He is told to raise his head. This seems to me to be more comfortable than the tipped position. The towel is then adjusted, giving exposure of only the anal opening. This has proven worth while, especially in hospitals where nurses previously had an aversion to a proctoscopic examination, particularly in male patients.

I always tell the patient there may be abdominal discomfort and a feeling of defecation, but assure him this will not happen.

Paper towels are then placed on the patient's legs, and below the feet, three or four 12-inch cotton applicators, some tissue and the proctoscope. Having lubricated the scope for a distance of about 2 inches, the tube is placed against the anus, the obturator end toward the symphysis. This is almost a vertical position. The 'scope is then pressed down, and the patient is instructed

to cough, thereby relaxing the sphincter, with a downward swing of the handle end, until the obturator end points toward the umbilicus; the 'scope enters the rectum up to a point 3 inches from the anus.

The obturator is removed, and the end of the tube is passed from right to left, front to back. The rectal ampulla, valves, color and tone of the mucosa are visualized.

The tube is then passed upward for 5 or 6 inches.

At a point about 7 inches from the anus, we reach the rectosigmoid junction. One must then follow the lumen of the bowel to the right, or left, as the position varies. Should there be a muscle spasm, air dilatation may be used to distend the bowel. If one proceeds slowly, this is not necessary.

The tube is then passed to a point 12 to 15 inches from the external opening. Assurance that all is going well, and an occasional pat on the small of the back, keeps the patient relaxed; making it easier for both the examiner, and the examined.

As the tube is slowly withdrawn, the rectal mucosa is examined for diverticula openings, neoplasm, nematodes, blood vessels, increased mucus or blood, and bleeding areas, ulcerations.

Should there be considerable fecal material, mucus or blood, a pledget of cotton may be placed beyond the end of the tube, and with the obturator, pushed into the lumen of the bowel.

Ulcerations or small openings not clearly visible, may be brought into view with the use of the microscope lens. Should there be neoplasm found, biopsy may be performed. The use of red or green cellophane between slides, as advocated by Felsen, may bring ulcers or blood vessels into better view. Red brings the vessels into view, and the green will show the edges of ulcers more clearly.

As the tube is withdrawn, each valve is examined on the upper and lower surfaces, especially at the base for neoplasm, or polypoid growth. It is in these areas that adenoma has been frequently missed.

The tube withdrawn to 3 inches, the obturator is placed, and the same direction followed as in entering. The tube is removed and placed in a paper towel. The used material is also placed in a paper towel. The area is cleansed with tissue, and all are placed in a receptacle.

The patient is then instructed to lie on the left side for a few moments before assuming the standing position. This will prevent fainting or dizziness.

I can think of nothing more fitting to close this paper than the following poetic lines:

Give to mine eyes — Give to mine hands
The power to see — That sense of touch
The source of hidden ills. — The throb of pain to still.

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MSMS FOUNDATION FOR POSTGRADUATE MEDICAL EDUCATION

Digest of Trust Agreement

Date of Trust.—The Trust Agreement between the Michigan State Medical Society and the Michigan National Bank, Trustee, was signed June 18, 1942.

Purposes.—The Michigan State Medical Society establishes an endowment fund to be known as the "Michigan State Medical Society Foundation for Postgraduate Medical Education," the net income to be expended (a) to provide postgraduate instruction relating to the science of medicine and surgery; (b) to conduct clinics and courses of instruction for doctors of medicine resident in Michigan; and (c) to be used for such other purposes of a medical educational nature as may be determined by the Michigan State Medical Society.

Initial Gift.—The State Society deposits with the Trustee the sum of $10,000 in cash and bonds, to create the MSMS Foundation, as first contribution to the principal of said Trust, the net income therefrom to be used for the purposes set forth above. This money and all additionall funds shall be kept in trust by the Michigan National Bank, Trustee.

Gifts from Others.—Other donors may add to the principal of this Trust by gifts, by will or otherwise; any such donations having a fair market value of not less than $5,000 may be given a special name by the donor, and the net income thereof shall be used as directed by said donor.

Powers of Trustees.—The powers of the Trustee to hold, manage, control and care for all funds and property are specifically outlined in the Trust Agreement, provided that no sales or purchases of investments shall be made without the written approval of the Michigan State Medical Society's Trust Committee (composed of the Chairman of The Council, the Chairman of the Finance Committee, and the Treasurer of the Society).

The disbursement of income shall be made as directed by the Michigan State Medical Society, upon orders signed by the Trust Committee. The Trustee shall keep a true account of all the affairs in the Trust and render a report to the MSMS December 15 annually.

Successor Trustee.—The Trustee has the right to resign, upon due written notice, whereupon the Society shall select a successor Trustee within a 60-day period. The Society shall have the right to change the Trustee at any time, upon due written notice.

Continuance of Trust.—The instrument of Trust and all provisions thereof shall continue until terminated. In the event the Trust is terminated, all such assets shall be used and applied by the Michigan State Medical Society for the purposes hereinabove set forth.

Donations and Gifts.—All donations and gifts to the Foundation shall be made to and in the name of the Michigan National Bank, a corporation, Trustee of the MSMS Foundation for Postgraduate Medical Education.

Cooperation and Direction, or Obstruction

LAY organizations and agencies frequently plan and promote various activities having to do with medical matters. This fact may indicate that there are medical needs which the profession has overlooked or has neglected. Frequently, these activities become accomplished facts before the medical profession is consulted.

Too often in the past physicians have refused to cooperate with lay agencies and have frequently attempted to obstruct their activities. This reaction is a perfectly normal one. However, coöperation and active direction by the medical profession have accomplished much good; from the standpoint of public relations they are most valuable.

Alert medical leaders should constantly be watching and studying the public trends in relation to medical services. They should have plans to meet these medical needs before they are demanded by the public and before lay agencies have inaugurated them. However, when a lay plan for medical service which has merit is presented, the profession should coöperate and assume the direction of this medical activity. Attempts to obstruct such plans react badly upon the medical profession.

W. H. Cummings

President, Michigan State Medical Society

President's

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EDITORIAL

HOME SERVICE

■ The Army and Navy have taken to themselves most of our active working doctors. That is not a job for the halt, the tired, the older man who is using all his energy in his daily run of life. But this very fact puts an added burden upon those left behind. The world has just passed through a great depression. A new order is developing. Many sociological problems have been met. Contacts of doctors with various government relief agencies have not always been satisfactory. During the past few years, however, by constant effort, by conference, by agitation, by every means at hand those problems have been gradually brought to a more economically sound solution.

A few of the doctors in each community have always had to shoulder the burdens of leadership and work out these problems as they have arisen. The doctor willing to work the hardest is usually the one who must solve these problems. The one with a large income, who has no personal economic worries, is often not interested: "Oh, yes. That should be done, but you know I haven't time for such detail!" The other fellow must have time for "such detail" if he is to eat.

But times have changed. Both the struggling young doctor building a practice and many of the older ones willing to work have gone to war. The infirm and the aging have all been left behind, together with many younger and more active doctors, who have been declared essential, and who are doing triple duty. If the sociological advances and the economic arrangements of the past few years are to continue, those left at home will have to do the work. They may see no present urge when too busy for their own health, but signs are developing of an effort to "slip" the medical profession back a notch, placing over it more controls and restrictions and demanding more, gratis.

With the new Legislature and Congress in session constant contacts with Legislators and Congressmen will be necessary in order to keep us acquainted with legislation in which we are interested, and to make available to them our best judgment in problems of health, medical education, and myriads of other matters for which they turn to us for advice.

Members of the profession who have gone to war will one day return with a duty well done. Return to what? Will those on the home front have done their duty as well? There are many small and large jobs to do, and now the men who dislike to take puttering jobs must do so. Medical societies must function if the profession is to grow in service and prestige. Those at home must now be the officers and committee members and must do the work. To be asked to assume some of the responsibilities of guiding medical affairs is a compliment and should be willingly accepted by all. Willing workers are needed more than ever before.

No member of the profession should place himself or his wishes above the call for service. Some are already carrying more than their fair share of the burden. If all were willing no one would be overly driven, the necessary things would be done, and all would be right with the medical world.

DOCTORS "FROZEN"

■ At Christmas time the news services carried an account of the freezing of doctors in Michigan. Paul R. Urmston, M.D., Michigan Consultant to the War Manpower Commission, announced that no more doctors would be taken into the armed forces for the balance of 1942 and the first part of 1943. Early in the past year a quota had been set up for all the states, based upon population, number of doctors and probabilities of availability for military service, and needs of civil and industrial practice. Michigan had passed this number with 134 per cent, not counting the interns and house physicians called to the services.

It was announced that except for those whose commissions were in process, no others would be called. A survey was started at the same time to determine what the civilian and industrial needs of the state would be. Each county was asked to report, and a tabulation of the reports received show only a few critical areas in the state. These

are areas that had very few doctors before the development of new war industries, and have now become critical as a result of the war effort. Some have lost their doctors by recruiting service "draining the state dry" of doctors. Approximately fifty to seventy-five doctors for all of Michigan would supply the needs thus established. There is no legal way as yet to relocate doctors, thus taking them out of over-supplied places and into areas of shortage. However, it is hoped that doctors who could be so used will volunteer. There are without doubt a few in our larger cities who are not satisfied with their present situation, and would be willing to move if shown a suitable place with good prospects.

Promise has been made that new quotas for 1943 will be made and may be announced from month to month, but will be built up with an eye to the record of the state in the past year, thus reducing the quotas of the states whose doctors have liberally responded. This was taken into consideration when Dr. Urmston made his reassuring announcement, which received considerable favorable editorial comment from our metropolitan press.

The Medical Recruiting Board functioned probably too well in Michigan judging by the result. Procurement and Assignment has worked under tremendous difficulties, lack of adequate or even essential help at times, and at others at cross purposes with the recruiting service which came in and used methods strangely suggestive of pressure. That must not occur again. When the new quotas are set up we must fill them. In this state there are still a few doctors of draft age who have not received commissions. Some of these were rejected for physical or other very good reasons, but some have not yet applied for commissions.

The soldiers and sailors who are fighting this global war are entitled to the very best medical services the profession can give, and that by doctors young or active enough to serve. The next call for medical officers will be a difficult one to fill because of the fact that there are so few men left who are suitable for military life. Those few together with the next age group will be invited to apply for commissions.

In the meantime the so-called "freezing" of the doctors was a good psychological move. It has reassured the public that their medical requirements will be met as well as it is possible. To increase this sense of well-being and protection, the doctors must coöperate and insure that services will be obtainable. Criticism has developed in some parts of the state over a different situation. A few doctors have been accused of making themselves hard to find. They will not answer calls during the night, but insist that all calls go to the hospital where one man will be on duty, and the next morning the patient will be returned to his regular doctor.* Another criticism is that some doctors are having their office receptionists tell people who call that the doctor will be unable to give them an appointment in less than ten days or two weeks. "If it is an emergency, go to some other doctor." Doctors so criticized are busy, but so are the others. Some way must be found to take care of these people. They must not be put off or allowed to suffer. But they should call during regular hours when possible.

The proposal has been made that doctors be recruited into the United States Public Health Service and assigned to areas where the people are not getting the attention they should have. The quickest way to bring about that situation would be to make it too difficult for the civilian population to find available doctors. We believe this is a rare condition involving only a few of our doctors, and that they are probably justified in their methods.

Considering the tremendous work being done by the great plurality of doctors at home who are serving by working three times as hard as ever before, they should have only the greatest praise instead of calling their attention to more service, which is done only because of demonstrated necessity. We are proud of the record.

NERVOUS AND MENTAL CONDITIONS AMONG SELECTEES

■ The following statement is submitted by the Committees on Mental Hygiene. Raymond W. Waggoner, M.D., Chairman:

In these days of stress, certain groups are apt to be requested to do more toward the war effort with less compensation than others who appear to profit from the emergency. Physicians as a group are always expected to perform "above and beyond the line of duty" and the present war situation is no exception. The al-

*This plan is being carried out in several cities by the County Medical Societies in an effort to conserve the doctor's rest time.

ready over-worked physician is requested to give freely of his time to the local draft board for the examination of selective service registrants. Sometimes, even though he finds a condition present which according to regulations automatically and permanently should place the registrant in Class 4-F, the local board will overrule the physician's recommendation and send the registrant to the Army Induction Board for induction. This experience is a definite mental trauma to the registrant; particularly is this true if the registrant had not previously known of his defects or if the defect happens to be mental. In addition to the harm done the registrant, there is the additional expense of transportation and of the Induction Board examination. Further, if by some chance the man should happen to get through the Induction Station examination, and this is not unlikely in certain types of mental defects, then the Government is shouldered with a serious responsibility which might have been averted had the registrant been correctly handled at the time of his local board examination.

The psychiatric problem is a particularly important one since many potential soldiers who have mild or serious psychiatric defects, making them incapable of adjusting in military service, still appear outwardly normal. Oftentimes because the physical appearance is good, the local board may consider that such a person should go into Army Service. These may be the very ones who are harmed most by the experiences at the Induction Station. Such a man may be very anxious to get into the Army and yet once in serves as a focus of discontent and maladaptation. The physician at the local board can do much to prevent such unfortunate experiences by the careful study of the situation at the time of the original examination. If the case is borderline, then the examining physician should make adequate notes on the proper form concerning the conditions found. *It is very important* that this information be available to the examiners at the Induction Station. In any case where the local board does not cooperate, a report should be made to the Mental Hygiene Committee of the State Medical Society or to the Selective Service Headquarters in Lansing. It should be noted that men rejected by Selective Service and at the Induction Stations may have arrangements made in the near future for referral to the local physician for treatment.

Such careful study would be almost impossible in most of the selective service examinations, which are necessarily conducted in haste. That information is necessary and should be at hand. Provisions have been made for family doctors having personal knowledge of selectees to give that information in writing to the examining physician. If doctors having patients who are mentally so neurologically unstable and are subject to the draft, would make that information available, a real service would be rendered, and probably many psychiatric episodes would be forestalled. In order to accomplish anything at the selective service examinations more than a mere screening must be done. A complete examination as at first is the only answer. A well-known psychiatrist was invited to contribute on this subject, and his editorials immediately follow.

OUR EIGHTEEN-YEAR-OLDS

■ Every physician knows he can expect to see some venereal disease in patients who are eighteen, or even younger, but the predominant incidence of venereal disease is not in that age group. Boys at eighteen are usually a fairly clean group; they are sophisticated (and the word is used as Webster intended), it is true, they are adventurous and should be, and they are going to become soldiers, sailors and marines, and they want it so. They are going to fight battles for our country, for you and for me. For your daughter, and your daughter and your daughter, who is still only eighteen or younger, or perhaps your granddaughter. When they come back to civilian life, those eighteen-year-olds will be the husbands of your daughter, and your daughter, and your daughter, or, perhaps, your granddaughter, and you do want them to be all you expect so far as health is concerned, don't you?

Then keep this thought in mind. If you fail to report and isolate a single case of gonorrhea or syphilis, you are guilty of a ruined life somewhere in the future and, who knows, it might be your daughter, or your daughter, or your daughter, or perhaps, your granddaughter; and it could be your son. (Contributed).

THIRTY THOUSAND DOLLAR MISTAKES

■ How long and how often could such expensive errors be made without ultimate bankruptcy? Yet according to information already published, those thirty thousand dollar errors are occurring at the rate of between two and four hundred times a week, and have been doing so for more than a year. Suppose we take the premise that such was the case for the year just past—1942, and suppose we split the difference between two hundred and four hundred, and use three hundred per week. The total number of errors was 15,600; and the cost at $30,000 per error would be 468 million dollars. It sounds fabulous, doesn't

it?—yet that is what the year 1942 will cost this country during the next twenty years for the misfits from psychiatric conditions who were taken into military service. And keep in mind that is just for one year, and the figures used are on the conservative side.

Perhaps the opinion will be mentioned that even though 15,600 cases were found and eventually discharged from military service, certainly no one would be so gullible as to think and state that such cases are due to military service, and that your government will compensate such cases because they occurred "in line of duty." Yes, your government will do that very thing, for with World War I as a standard, it will not take much imagination to see that Congress will statutorily state the etiology of most mental diseases with a definiteness that can't be disputed by any psychiatrist.

The medical profession should be concerned about this situation and do its ultimate for national defense in preventing as many as possible of these mistakes. But how? Well, in any case where there is a shadow of doubt, the local draft board should defer the case until properly investigated by a social agency. If the doubt arises at the induction board, the case should again be deferred until investigated by a social agency. It would seem that with a little attention, many thousands of capable young women could be taught to make an investigation from a well-formulated plan that would be particularly relevant to the military service; for since we have had armies and wars throughout all the eras known to man, doubtless there can be formulated a fair model of what an efficient soldier should be, and that formula could be used on all doubtful cases. Many cases that are now called "in line of duty" will then be found to exist now "prior to enlistment" and entrance to military service will be precluded.

If a single social agency should exclude only one in the year 1943, it would be a sound investment, and if we had them with every draft board, and induction board, that three hundred a week could be reduced almost entirely. (Contributed)

WAR DOCTORS

■ Announcement of military postgraduate courses starting immediately has been made in ten medical schools, including the University of Michigan. Doctors who go into military service are very largely being sent to postgraduate studies for a few weeks. Admiral McIntire told the Conference of State Society Secretaries and Editors that his men would be sent back to civilian practice after the war much better men than when they left for the war.

This promise seems to be on the way of fulfillment. The University Medical School will be devoted to war training for the next six months, having about two hundred physicians there at a time, and many are going to Washington for training in tropical and oriental diseases. This is as it should be.

Doctors of Medicine who are privileged to be war doctors will come back to us grown in stature, as so many did after the last war. In that other war there were schools established for instruction, but in no way comparable to what is now being done. These men so well trained will of necessity become better doctors, and they will literally have had a world of experience. The best sort of instruction is by doing, and they will see and do many things. War has always opened up new fields in medical knowledge, and this one already is developing new techniques. We are inclined to offer congratulations to our war members because of the opportunities that are at their door.

MILITARY MEMBERS CHANGING ADDRESSES

Except as hereinafter provided no parcels shall be accepted for dispatch to A.P.O.'s outside U. S. unless they contain such articles only as are being sent at the specific written request of the addressee. Individual copies of newspapers or magazines shall be accepted for dispatch to A.P.O. outside the U. S. only where subscriptions are specifically requested in writing by the addressee or for which subscriptions are now in effect. Such copies to individuals shall be accepted only from publishers who shall place on the wrapper, or on the publication when a wrapper is not used, a certificate (which shall be regarded as sufficient to authorize their acceptance) reading as follows: "Mailed in conformity with P.O.D. order No. 19687.—*Postal regulations regarding export of journals.*

■ THE JOURNAL wishes to send all its issues to our members in military service, but their addresses are constantly changing. When a member goes into the service, his next JOURNAL is mailed to his old address; shortly a notice comes back from the Postmaster: "Dr. X is not at such address—his present address is——," or no new address is given. That copy of THE JOURNAL is lost. The address is changed in our records and on the addressograph machine, and

the next issue of THE JOURNAL goes to the new address. Frequently we receive another card from the Postmaster, which may or may not give us a new address; but another number of THE JOURNAL is wasted. We have had as many as eight such changes for a single man. It takes most of one clerk's time to try to keep our mailing list up to date.

If members who go into military service would send a card to the publication office (2020 Olds Tower, Lansing) giving exact information where to send THE JOURNAL, it would greatly simplify matters as well as assure delivery of THE JOURNAL. If the military address is not permanent or approximately so we would suggest that a *permanent home address* be furnished: i.e., wife, father, bank, Trust Company, from whence THE JOURNAL may be forwarded to the final address. If our members will coöperate and keep us informed we will do our part. When the permanent home address is not supplied, we shall necessarily have to stop mailing THE JOURNAL, to stop needless waste of vital paper stock.

THE JOURNAL is being submitted to Military Censor before each mailing to make it eligible for delivery to our overseas members. As soon as members are given an A.P.O., number address, we request them to notify the publication office at once, to help insure receipt of the State Society publication.

CONTINUE SOCIETY ACTIVITIES

The need for constant activity of our medical societies and committees has been mentioned editorially, but cannot be too strongly stressed. This has been emphasized by the County Societies Committee of the Council in their annual report to the Council from which we quote:

Postgraduate Medical Education Programs for County Societies.—This was discussed, and it was recommended to the county societies that every effort be made by them to maintain staff and county society meetings; where it is impossible or not feasible to bring in outside speakers, the local members should present subjects. More use should be made of the MSMS Speakers' Bureau, it was felt by this Committee.

The County Societies Committee also recommends that the Postgraduate Conferences in those cities where they are held at present be scheduled to coincide with county society meetings in order to bring the greatest number to the postgraduate sessions. It was also felt that the special postgraduate programs for the Upper Peninsula should be continued, if at all possible.

Many societies have attempted to consolidate staff meetings and their society meetings, with marked increase of enthusiasm and attendance. With continued effort much good can be thus accomplished, and medical organization benefited.

RETURN TO WHAT?

■ What will the postwar medical world be? Signs already point the way.

Closest to home but lost in the temporary rush of medical practice is the question of medical relief. For ten years we have struggled to take medical relief out of bureaucratic hands and give it some sympathetic direction by medical minds. With the relief rolls much smaller and all able-bodied persons working, medical relief demands have reached an all-time low. The doctor takes them in his busy stride and forgets to note that he was called by the social worker and not by the patient; the social worker largely determines the services! Is this not the time to correct some bad abuses and precedents established by medical default?

Second sign: The right to practice medicine must be definitely clarified. Standards of preparation and education must be maintained, if not improved. As a war measure and to make more doctors of Medicine available, it is urged that licensure requirements be suspended; this might be a boomerang after the war.

Third sign: Plans to place more central control over medical practice, including compulsory health insurance with its ramifications of controlled doctors are apparent.

A bright side, however, will be presented in the postwar era. We have in the last generations solved the problems of Typhoid Fever, Diphtheria, Smallpox, and Malaria. Tuberculosis is on its way out. Acute Infections are being eliminated. Chemotherapy is only beginning. Pneumonia and the common cold will respond to further research. A generation ago the young doctors were told their practice of medicine would soon be preventive. We can still tell them that, but we know it will continue to be largely curative.

Curative Medicine has changed in its Armamentarium, in its scope of disease conditions as well as its preventive principles.

After this war period the public will have become much more conscious of its doctors of medicine. People have had to consider the doctor's health and recreational life as never before. Opportunities of leadership and counsel will in-

crease. More of our superlatively trained men should seek public life as legislators, lawmakers, and as administrators of government.

The postwar medical world will be a different one, but closely allied to the prewar world. Advances have always followed periods of stress. And it is our task to guide those advances into the channels most helpful to us and to our people, the patients whom we serve. The keenest observation and thought of our members must be given these problems to assure the correct answers. There is opportunity for all. If all will give their best efforts, the future is bright.

But to ensure such a future, medical societies, academies and economic groups must be active—far more than today. The scientific work must go on to reach the goal ahead. Economic studies and efforts were never more important. The tendency of doctors of medicine to forget the experience of only a few years ago in the presence of present strenuous times is not good. Lessons learned in sweat should be remembered. Success and happiness require constant effort.

PERCY JONES HOSPITAL

■ Percy Jones General Hospital is pictured on our cover this month. It has been repeatedly stated that the Army bought the Battle Creek Sanitarium. This is not true. The Sanitarium sold one block of buildings and is still operating in several of its remaining buildings across the street.

This view is from the rear across beautiful Irving park, a restful spot of Battle Creek. On the opposite side of the park is new Community Hospital and just across another street at the northern end is Leila Hospital.

COUNCILOR L. J. JOHNSON

■ Lieutenant Commander L. J. Johnson of Ann Arbor reported for duty with the Navy, January 16, 1943. He resigned as Councilor, having served meritoriously since his election to fill the vacancy created by the election of Howard H. Cummings to the position of President-elect in September, 1941.

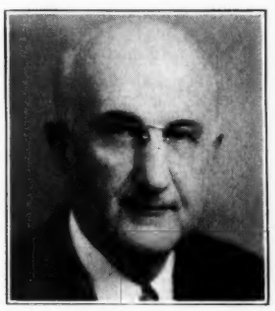
Dr. Johnson has, during his year of service, endeared himself to his fellow members of the Council, and they regret his departure, even though they congratulate him on his new undertakings. We wish him Godspeed.

Colonel Henry R. Carstens, now at Camp McCoy, was the first official of the State Medical Society to answer the call, being president of the society at the time.

The first Councilor to go into service was Major Holmes, who went first to Camp Hulan, Texas, and is now at Washington, D. C., studying oriental and tropical diseases for two months, January and February. Lt. Commander Johnson is the second Councilor.

COUNCILOR DEAN MYERS

■ President Cummings has appointed, and the Council confirmed, Dr. Dean Myers of Ann Arbor to fill the vacancy on the Council caused



DEAN MYERS, M.D.

by the military service of Lt. Commander Johnson. Dr. Myers is a man of much experience, having at one time been Professor of Ophthalmology of the University of Michigan, Homeopathic Department. His willingness to work for medical advancement, and his pleasant and friendly understanding bespeak for him a successful service on the Council.

WAR BONDS

■ Again we urge everybody to buy more war bonds. If this war is to be successfully prosecuted more and more credit will be needed. It is now estimated that it takes seven tons of shipping to send abroad and maintain one soldier. The President announced a million and a half already over seas. Think what that means, and then take a pencil and see how much more than ten per cent of your income can be put to work to get our boys back home. This time we want them back permanently. That will take some doing, and we at home can do our part by furnishing the wherewithal. Buy, and buy, and buy bonds.

OFFICERS

■ Other newly elected officers, selected at the midwinter meeting of the Council in Detroit, January 16 and 17, 1943, are F. Fernald Foster, reëlected Secretary. His long tenure of that office has been marked by the most unstinted service, reaching to practically every county in the state nearly every year. His travels have been extensive and time-consuming. He knows the profession of the state as does no one else. He is eminently fitted for the position, and will continue to serve in his efficient manner.

Dr. Wm. A. Hyland of Grand Rapids has held the position of Treasurer for many years, and has filled it to complete satisfaction. His personal associations and affiliations, and his financial bent make him ideal for this office, and we are happy that he will continue in it.

Dr. Wilfrid Haughey of Battle Creek is the new editor. He has been acting editor since the editor, Major Holmes, entered the Army service. Dr. Haughey has had previous editorial experience, the MICHIGAN JOURNAL in 1909 to 1913 and the Phi Beta Pi Medical Fraternity *Skull and Pelvis* for several years.

Dr. Otto Stryker was appointed by President Cummings to the Councilor position held by Major Holmes following his resignation upon entering service, and confirmed by the Council. Councilor Stryker is not new to Councilor duties, having served as Speaker of the House and ex officio member of the Council.

L. FERNALD FOSTER, M.D.
Bay City
Secretary

WM. A. HYLAND, M.D.
Grand Rapids
Treasurer

WILFRID HAUGHEY, M.D.
Battle Creek
Editor and Councilor
Third District

O. L. STRYKER, M.D.
Freeport
Councilor Eleventh District

DO NOT FORGET YOUR POSTGRADUATE PROGRAM for 1943*

Intramural Courses

Allergy
Anatomy†
Diseases of Blood and Blood-forming Organs
Diseases of Genito-urinary Tract
Diseases of the Heart
Electrocardiographic Diagnosis
Gastroenterology
Gynecology and Obstetrics
Internal Medicine (Summer Session Course)
Laboratory Technique
Neurology and Psychiatry
Nutritional and Endocrine Problems
Ophthalmology and Otolaryngology
Pathology
Pediatrics
Proctology
Roentgenology

Extramural Courses Centers

Ann Arbor
Bay City
Cadillac
Flint
Grand Rapids
Kalamazoo
Jackson
Mt. Clemens
Sault Ste. Marie, Marquette, Houghton, Ironwood, Powers

*The Committee on Postgraduate Medicine feels that the needs of our profession due to the emergency require even an expansion of postgraduate opportunities. At the same time all must realize that shortage of teaching personnel may require a sharp curtailment. Ample notice will be given either through THE JOURNAL or by personal communication should omissions or changes become necessary.

†The course in Anatomy will be given on Wednesdays throughout the second semester, beginning February 3, at 1:00 P.M., at the University of Michigan.

ANNUAL MEETING OF THE COUNCIL, MSMS

January 16 and 17, 1943

HIGHLIGHTS OF THE MEETING

- Membership of State Society at an all-time high (4,714).
- Fifteen hundred Michigan Doctors of Medicine serving in the armed forces.
- "Industrial Medical and Surgical Clinic," April 8 in Detroit, approved.
- Study of postwar postgraduate programs and special refresher courses recommended.
- Integration of all medical postgraduate programs in Michigan recommended.
- Proposed amendment to Michigan Medical Practice Act, to permit licensing of graduates of wartime telescoped medical courses, approved.
- Auditors' Report for 1942, and Budgets for 1943 approved.
- Medical examinations prior to "hardening" program for high school students studied and approved.
- Wayne County Medical Society resolution re seekers after public office who favor federalized medicine adopted.
- Progress Report on Michigan Medical Service presented.
- Dean W. Myers, M.D., Ann Arbor, chosen as new Councilor of 14th District.
- Secretary, Treasurer, and Editor elected.

—FIRST MEETING—

January 16, 1943—10:10 A. M.

1. *Roll Call.*—The meeting was called to order by A. S. Brunk, M.D., Chairman, on Saturday, January 16, at 10:10 a.m. in the Statler Hotel, Detroit. Those present were Councilors Brunk, Umphrey, Riley, Haughey, Hubbell, Moore, Morrish, DeGurse, Barstow, Perkins, Stryker, Miller, Huron and Beck; Speaker Ledwidge, President Cummings, President-elect Keyport, Secretary Foster, Treasurer Hyland, Past President Corbus, and Executive Secretary Burns.

Absent: E. F. Sladek, M.D., and L. J. Johnson, M.D. (in Navy).

2. *Minutes.*—The minutes of the meeting of The Council held September 24, 1942 and of the Executive Committee meetings of October 21, November 18, and December 17, were approved on motion of Drs. Stryker-Umphrey. Carried unanimously.

3. *Secretary's Annual Report.*—The annual report of the Secretary was presented by L. Fernald Foster, M.D. and *referred to the County Societies Committee.*

SECRETARY'S ANNUAL REPORT—1942

I herewith submit the report of the Secretary for 1942—the first World War II yearly report.

Membership

Despite the fact that the forecast of one year ago stressed the possibility of a decided decrease in paid memberships, the Society's member roster for 1942 showed that another all-high was recorded. Many members entering the military services paid their 1942 dues, hence the real impact of the war will not be felt until 1943.

In 1942 there was a total of 4,714 members, including 59 emeritus, honorary and retired members, and 210 military members. The total paid memberships were 4,445 with net dues of $46,184.54 accruing to the Society. The number of members with unpaid dues for 1942 was 85. The membership tabulation for the years 1941 and 1942 showing net gains and losses, unpaid dues and deaths is as follows:

1941	*1942*	*Gain*	*Unpaid*	*Deaths*
4,495	4,655	160	85	52

MEMBERSHIP RECORD 1942

	1941	*1942*	*Military*	*Loss*	*Gain*	*Unpaid*	*Deaths*
Allegan	23	24	1	—	1	—	1
Alpena-Alcona-Presque Isle	20	20	1	—	—	—	1
Barry	14	13	—	1	—	—	—
Bay	81	70	5	11	—	1	1
Berrien	61	55	5	6	—	3	—
Branch	20	21	3	—	1	—	1
Calhoun	109	99	16	10	—	—	2
Cass	12	14	—	—	2	—	—
Chippewa-Mackinac	18	21	—	—	3	—	—
Clinton	12	12	—	—	—	2	—
Delta-Schoolcraft	27	24	—	3	—	1	—
Dickinson-Iron	22	19	2	3	—	—	—
Eaton	29	29	—	—	—	—	1
Genesee	183	188	1	—	5	2	2
Gogebic	25	23	—	2	—	—	3
Grand Traverse-Leelanau-Benzie	41	41	2	—	—	1	1
Gratiot-Isabella-Clare	40	40	—	—	—	—	1
Hillsdale	25	24	2	1	—	—	1
Houghton-Baraga-Keweenaw	40	36	3	4	—	—	1
Huron	12	11	—	1	—	—	—
Ingham	154	153	3	1	—	—	—
Ionia-Montcalm	40	42	—	—	2	—	1
Jackson	94	92	2	2	—	—	—
Kalamazoo	118	118	8	—	—	1	1
Kent	243	239	14	4	—	11	3
Lapeer	14	15	—	—	1	—	2
Lenawee	45	39	4	6	—	4	—
Livingston	19	16	—	3	—	—	—
Luce	11	11	2	—	—	—	—
Macomb	42	39	1	3	—	3	—
Manistee	14	13	1	1	—	—	—
Marquette-Alger	42	36	2	6	—	3	—
Mason	8	13	—	—	5	—	—
Mecosta-Osceola-Lake	15	15	1	—	—	1	1
Medical Society of North Central Counties	23	19	1	4	—	—	—
Menominee	13	13	1	—	—	—	—
Midland	16	16	—	—	—	1	—
Monroe	38	39	1	—	1	1	1
Muskegon	79	81	1	—	2	—	—
Newaygo	12	10	1	2	—	1	—
Northern Michigan	28	31	1	—	3	2	—
Oakland	151	148	8	3	—	4	2
Oceana	11	12	—	—	1	—	—
Ontonagon	8	7	1	1	—	—	1
Ottawa	35	32	1	3	—	3	1
Saginaw	98	96	7	2	—	2	3
Sanilac	13	15	—	—	2	1	—
Shiawassee	29	29	—	—	—	—	—
St. Clair	54	54	—	—	—	—	—
St. Joseph	25	22	3	3	—	—	1
Tuscola	25	25	3	—	—	—	—
Van Buren	28	25	2	3	—	1	—
Washtenaw	181	179	15	2	—	6	1
Wayne	1933	1945	81	—	12	29	19
Wexford	22	22	4	—	—	—	—
Military Members	—	210	—	—	210	—	—
	4,495	4,655	210	91	251	85	52
		4,495			91		
		160			160		

Paid Members	4,445
Military Members	210
Emeritus & Honorary Members	59
Total	4,714

Deaths During 1942

We regretfully record the deaths of the following fifty-three members during 1942:

Allegan County—E. D. Osmun, M.D., Allegan.
Alpena County—A. R. Miller, M.D., Harrisville.
Bay County—John W. Dickinson, M.D., Oscoda.
Branch County—H. A. Schneider, M.D., Coldwater.
Calhoun County—C. G. Fahndrich, M.D., Battle Creek; Claude E. Hale, M.D., Marshall.
Eaton County—A. G. Sheets, M.D., Eaton Rapids.
Genesee County—B. E. Burnell, M.D., Flint; E. D. Rice, M.D., Flint.
Gogebic County—W. C. Conley, M.D., Ironwood; Theodore S. Crosby, M.D., Ironwood; John Reid, M.D., Ironwood.
Grand Traverse-Leelanau-Benzie—George A. Holliday, M.D., Traverse City.
Gratiot-Isabella-Clare County—Fred J. Graham, M.D., Alma.
Hillsdale County—J. L. Yeagley, M.D., Waldron.
Houghton County—C. H. Rupprecht, M.D., Calumet.
Ionia-Montcalm County—Herbert M. Maynard, M.D., Ionia.
Kalamazoo Academy of Medicine—Richard F. Weirich, M.D., Marcellus.
Kent County—C. DeJong, M.D., Grand Rapids; Albertus Nyland, M.D., Grand Rapids; G. W. Webster, M.D., Grand Rapids.
Lapeer County—Fred R. Hanna, M.D., Lapeer; Howard K. Shrom, M.D., Imlay City.
Mecosta-Osceola-Lake—Glenn Grieve, M.D., Big Rapids.
Monroe County—E. M. Cooper, M.D., Rockwood.
Oakland County—Stuart Terry, M.D., Pontiac; H. W. Williams, M.D., Pontiac.
Ontonagon County—Frank W. McHugh, M.D., Ontonagon.
Ottawa County—W. M. Tappan, M.D., Holland.
Saginaw County—Frederick W. Freeman, M.D., Saginaw; N. F. McClinton, M.D., Saginaw; Keith M. Morris, M.D., Saginaw.
St. Joseph County—J. H. O'Dell, M.D., Three Rivers.
Washtenaw County—Reuben Peterson, M.D., Duxbury, Mass.
Wayne County—Leopold Adler, M.D., Detroit; Norman M. Allen, M.D., Detroit; Oscar S. Armstrong, M.D., Detroit; W. L. Babcock, M.D., Detroit; Fred N. Blanchard, M.D., Detroit; Don M. Campbell, M.D., Detroit; Angus L. Cowan, M.D., Detroit; Arnold T. Droste, M.D., Dearborn; Harry S. Gorelick, M.D., Detroit; David J. Levy, M.D., Detroit; Frank J. MacDonell, M.D., Detroit; Carl C. McClelland, M.D., Detroit; Nelson McLaughlin, M.D., Detroit; Stanley G. Miner, M.D., Detroit; Edward G. Minor, M.D., Detroit; Irwin H. Neff, M.D., Detroit; R. T. Tapert, M.D., Detroit; Jean A. Vernier, M.D., Detroit.

Financial Status

On December 26, 1942, the close of the fiscal year, the books of the Society were audited by Ernst & Ernst.

Review of their published report revealed the following financial condition of the Society. Assets are listed at $66,076.94 and are $10,974.36 higher than a year ago. The net worth is $40,153.21, showing a decrease of $8,618.67, due chiefly to the transfer of $10,000.00 of Society funds to the Foundation for Postgraduate Medical Education.

The income from dues was $52,738.00 of which $6,587.97 was allocated to the JOURNAL. This allocation produced a JOURNAL profit of $1,703.93. Interest was received in the amount of $1,068.28, an increase of $70.98 over last year. Miscellaneous income of $62.12 gave a total income of $48,984.36. This is a decrease of $1,546.77 from a year ago.

The Society expenses totaled $36,301.97, a decrease of $2,775.39 from last year. Other expenses are listed as $1,591.00, a loss from sale of securities and a provision for deferment of dues paid by military members of $11,700.00, making a total of $13,291.00. This amount subtracted from the net income of $12,682.39 leaves a deficit of $608.61 on the operation of the Society for the year.

Securities—The security portfolio consists of high grade bonds, approximately 50% of which are in United States Savings and Defense bonds. No change in the list has been made except for the sale of Associated Gas and Electric Corporation bonds. The quoted market price of the securities on December 20, 1941 was $30,674.06 as compared with $22,452.00 as of December 26, 1942. The difference is due chiefly to the transfer of bonds, having a market value of $9,359.00, to the Postgraduate Medical Education Foundation.

Medical Defense Funds—The audit of the Medical Defense Fund as operated by Dr. William A. Hyland, trustee, was made by our auditors. A balance on hand December 21, 1941 was $4,458.32. Interest in the amount of $325.00 and profit from sale of securities of $39.50, and the increased value of securities of $45.00, makes a total of $4,867.82. Expenses consisted entirely of legal fees and amounted to $1,319.15, leaving a trust balance on December 26, 1942 of $3,548.67; a shrinkage of $909.65 in the net value of the fund resulted.

The Journal.—THE JOURNAL had allocated to it $6,587.97 from members' dues. Other income was from subscriptions, advanced reprint sales, advertising sales and JOURNAL cuts, making a total income of $20,518.08. The expenses included the editor's salary and expense, amounting to $2,250.00, printing and mailing of THE JOURNAL, $12,229.95, and these with other relatively small expenses, made a total of $18,814.15. This was $414.15 over the budget estimate. Without the allocation to THE JOURNAL from members' dues there would have resulted a loss of $4,884.04 in the operation of THE JOURNAL for this year.

Further comment regarding military members' dues —to quote Ernst & Ernst (page 7), "The Society has adopted the policy of waiving payment of dues of members in the armed forces of the United States, and in the event the current year's dues were paid, to allow one year's membership without charge at the expiration of military service. A provision of $9,900.00 has been made to defer the income received from those members known to be in service who have paid dues for the year in which they entered service. This amount has been based upon reports from county societies. An additional provision of $2,400.00 has been made for deferment of dues of members in military service who have not been reported to the Society as being in service."

The budget at the beginning of the year set up a reserve of $600.00 to cover this matter. Further study deemed it wise to set up under unearned income an item called "dues for military members applicable to a future year" in the amount of $9,900.00. An additional reserve of $2,400.00 was set up "for deferment of dues paid by military members not reported." This minus the $600 already set up makes a total of $11,700.00 to be set up as a reserve for military members' dues the year following their return to civil life. This does not take into account the yearly loss of income from these members while they are in service. The latter is to be considered in each yearly budget prior to the termination of the war.

Summary.—The assets increased by $10,974.36 while the income increased by $1,546.77. The expenses were reduced by $2,775.39. The excess of income over expenses was $1,228.62, but a net loss of $608.61 was sustained after deducting $11,700.00 reserves for military members and loss of $1,591.00 from sale of securities, making a total of $13,291.00. The actual expenses were $7,498.03 under the budget estimate.

The 1942 Annual Meeting

The Annual Meeting was held in Grand Rapids in September, 1942. Despite the War, a total registration of 1,746 was recorded. The 1942 attendance was very gratifying, surpassing our fondest expectations. At the time of the meeting hundreds of members were serving with the armed forces and those remaining at home were in the throes of practice readjustments.

The General Assembly type of Scientific program

was continued and with it the Discussion Conferences which were introduced at the 1941 meeting, and which met with much popular approval.

A modest scientific exhibit, consistent with available facilities, was presented in Grand Rapids. These exhibits were sponsored by various organizations and institutions.

Despite the great expense of providing a program of General Assembly essayists from out-of-state, a substantial profit again accrued to the Society as the result of a large and well-developed technical exhibit.

The difficulties of transportation in 1942 failed to in any way curtail the number of technical exhibits or to interfere with the appearance of the guest essayists, many of whom came long distances.

Every available exhibit space was sold; the registrants showed a keen interest in the exhibits, giving very generously of their time to the exhibitors.

County Secretary Conferences

Two County Secretary Conferences were held during the year, one in Lansing in January and one in Grand Rapids on the occasion of the Annual Meeting.

The January Conference featured one session held jointly with the County Health Director of Michigan and provided an excellent opportunity for an exchange of ideas with the health group.

The general program of the January Conference was devoted to subjects of a war character—Selective Service, Procurement and Assignment and related subjects. It was attended by more of the county secretaries than any previous conference.

Committees

All committee programs and projects were conducted without interruption during the year, despite the ever-mounting number of medical activities occasioned by the war conditions.

Most of the committee plans are of a long-range variety, and their continuity has been efficiently maintained.

Unfortunately time and space do not permit a detailed account of such committee's activity, but the high standard of committee endeavor was maintained in 1942.

Society Activities

During 1942 consistent contact was had with practically each of the 55 component societies through District Councilor meetings. These were attended by Councilors and officers and some committee chairmen and members.

Reports made on the occasion of these meetings showed a keen awareness on the part of each county unit of the activities and projects of the parent organization.

During 1942 your two secretaries contacted practically every county society.

The final development of the "Michigan State Medical Society Foundation for Postgraduate Medical Education" was completed in 1942, and the initial appropriation of $10,000 recommended by the 1941 House of Delegates was applied to this worthy endeavor.

Dissemination of society activity news was continued during the year by the issuance of nine Secretary letters. Of these five were sent to County Presidents and Secretaries and four went to every member of the society. In addition, three Victory Bulletins were mailed, two to County Society Medical Preparedness Committee members and one to all Members of the Society.

We now face another year of state society activity with the realization that more and bigger problems face those of the profession who are left at home to carry on organizational functions, and to maintain the professional practice of medicine.

We record with pride the honor roll of nearly 1,500 Michigan doctors of medicine serving with the armed forces. This splendid record, however, brings to bear upon our remaining members the responsibility of solving the inevitable postwar economic and social problems of medicine, and calls the vigilance in State and National affairs necessary especially during war time.

I respectfully recommend:

1. That during the year, due to transportation difficulties, the various district meetings be eliminated and that the inter-society public relations be maintained in so far as possible through communications and officer-committee-chairmen-Councilor-contact with the various components, and

2. That clarification be made of "Military Membership," especially concerning dues and postwar remissions.

3. That a study be made of definite plans for postwar postgraduate work and medical refresher courses designed to aid physicians returning from the armed forces; that the report of this study be presented to The Council at its next session.

Your Secretary cannot express too sincerely and earnestly to This Council his appreciation of its splendid coöperation and encouragement during the past year. Much commendation is due the committees for their splendid spirit and untiring efforts in the successful execution of many difficult tasks.

To Mr. Burns, Executive Secretary, and the executive office personnel, too much appreciation of their untiring efforts cannot be expressed. It is with regret that we record the loss of Mr. Lynn Leet of the executive office. He now serves as a First Lieutenant with the armed forces.

Mr. Burns is ever most helpful and coöperative and a true inspiration. To all of those who have aided so generously in the discharge of the duties of this office, your Secretary is truly grateful.

Respectfully submitted,
L. FERNALD FOSTER, M.D., *Secretary.*

4. *The Treasurer's Annual Report* was presented by Wm. A. Hyland, M.D., and *referred to the Finance Committee.*

TREASURER'S ANNUAL REPORT—1942

As Treasurer of the Michigan State Medical Society, I wish to submit the following report for the year 1942.

During the year, a total of $491.25 was received as income from interest coupons and dividends on bonds in the Treasurer's account, with interest accruing on United States Treasury Bonds, $194.50, not included.

The present value of the bonds and securities held by the Michigan State Medical Society, quoted market values as of December 1, 1942, is $22,452.00.

The following bonds were transferred to the Michigan State Medical Society Foundation for Postgraduate Education:

Five United States Treasury Bonds.
One Consumers Power Bond.
One United Light and Power Bond.
One Standard Oil Bond.
One Government of the Dominion of Canada Bond having a total market value on September 4, 1942, of $9,359.00, plus accrued interest of $102.22, making a total of $9,461.22.

In addition, two $1,000 Associated Gas and Electric Bonds were sold at market value on October 1, 1942, for $209.00. The money from this sale, plus $329.78, totalling $538.78, was deposited also with the Michigan National Bank as Trustee for the Michigan State Medical Society Postgraduate Fund, totalling $10,000.00.

Total cash on hand on December 31, 1942, in the Michigan National Bank of Grand Rapids—$772.80, (including disc. float. acct. $72.53).

The following securities were held by the Michigan State Medical Society on December 31, 1942.

	Quoted Market Value December 31, 1942
American Telephone and Telegraph	$ 2,150.00
Government of the Dominion of Canada	977.50
Canadian Pacific Railroad	1,440.00
Consolidated Oil Corporation	1,037.50
Consumers Power Company	1,075.00
Detroit Edison Company	2,212.50
New York Central Railroad	527.50
Union Pacific Railroad	977.50
United Light and Power Company	1,065.00
Grand Rapids Affiliated	880.00
Government Bonds carried at full value	10,109.50
	$22,452.00

Respectfully submitted,

WM. A. HYLAND, M.D., *Treasurer.*

5. *The Trustee's Annual Report* was presented by Wm. A. Hyland, M.D., and *referred to the Finance Committee:*

ANNUAL REPORT OF TRUSTEE FUND OF MICHIGAN STATE MEDICAL SOCIETY—1942

As Trustee for the Michigan State Medical Society, I wish to submit the following report for the year 1942:

The following bonds are held in trust for the Michigan State Medical Society:

Two New England Gas and Electric Bonds.
Two Southern Pacific Railroad Company Bonds.
One Grand Rapids Affiliated Bond.
One New York Central Railroad Bond.

The present value of these bonds is $3,517.50.

On August 25, 1942, one Grand Rapids Affiliated Bond was sold to General Fund for $939.50 to help take care of current expenses.

During the year 1942 a total of $325.00 was received as interest income on these bonds.

A total of $1,350.32 was paid out for legal fees during the year 1942.

Bills as yet outstanding amount to $70.83.

At December 31, 1942, there was no cash on deposit. Total value of Trustee Fund is $3,517.50.

Respectfully submitted.

WM. A. HYLAND, M.D., *Treasurer.*

6. *The Editor's Annual Report* was presented by Wilfrid Haughey, M.D., and *referred to the Publication Committee:*

EDITOR'S ANNUAL REPORT—1942

The form and appearance of THE JOURNAL has been continued throughout the year—except for two minor changes. The Readers' Service has been changed: instead of a page or two among the advertising pages, we are now using a short synopsis of the article in the heading of each paper, thus giving the reader a more compact survey of the paper without the necessity of turning pages. We would like to know the readers' reaction to this change which was approved by the Publication Committee in September. The other change has been the discontinuance of "Fifty Years Ago"—those reprints of papers published fifty years ago have a distinct historical value which is appreciated, but they were taking up too much space at the expense of current papers. We are considering other methods of developing interest in the history of medicine.

During the year we have published ninety-three original papers with an average of four and one-half pages in length. These have reached practically all fields of medicine, including the specialties, but all papers have been written with general practitioner reader-interest as the main factor. Twenty papers have been given strictly to general practice and nineteen to general interest. Twelve were eye, ear, nose, throat and bronchi—the largest group devoted to any one branch of medical practice. There were nine papers devoted to surgery, seven to chemotherapy, six to obstetrics, five to dermatology and urology, four to pediatrics, three to anesthesia, three to x-ray; the rest were scattered.

There have been forty-nine editorials and ninety-nine book reviews.

In August, Editor Holmes was called into the armed forces as a Major and sent to service. He turned the editorial material over to the chairman of the Publication Committee who carried on with the approval of the Council at the Grand Rapids meeting.

The Acting Editor found five papers from the 1941 meeting not yet printed, due to lack of space. That prompted the temporary suspension of "Fifty Years Ago." Of those papers all but one have been published and that one only came to hand less than a week ago. It will be our endeavor to have all of the current year's annual meeting papers published before the next year's meeting. There may be a problem in this regard because of the present dearth of papers being prepared and presented. With so many of our men in the war and the rest so busy, it is difficult to prepare papers.

Editor Holmes and the Acting Editor wish to take this opportunity to thank the Publication Committee for valuable help and sympathetic understanding, and especially Mr. Wm. Burns, the Executive Secretary, for most valuable suggestions and assistance.

Respectfully,

WILFRID HAUGHEY, M.D.

7. *Reports of Committees of the Council:*

(a) *The County Societies Committee report* was presented by W. H. Huron, M.D., Acting Chairman and *referred to the Finance Committee:*

ANNUAL REPORT OF COUNTY SOCIETIES COMMITTEE—1942

(1) *Roll Call.*—The meeting of January 15, 1943, was called to order at 8:10 p.m. in the Statler Hotel, Detroit, by W. H. Huron, M.D., Chairman pro-tem. Those present: Doctors Huron, R. J. Hubbell, P. A. Riley and A. H. Miller; also H. H. Cummings, M.D., and A. S. Brunk. Absent: E. F. Sladek, M.D., Chairman.

(2) *Postgraduate Medical Education Programs for County Societies.*—This was discussed, and it was recommended that every effort be made by county medical societies to maintain staff and county society meetings; where it is impossible or not feasible to bring in outside speakers, the local members should present programs and make more use of the MSMS Speakers' Bureau.

The County Societies Committee also recommends that the Postgraduate Conferences in those cities where they are held at present be scheduled to coincide with county society meetings, in order to bring the greatest number to the postgraduate sessions. It was also felt that the special postgraduate program for the Upper Peninsula should be continued, if possible.

(3) *Radio Activity During Wartime.*—The program of radio presentations as carried on by the MSMS Radio Committee under the chairmanship of Hugh Beebe, M.D., was discussed. It was the opinion of the County Societies Committee that Dr. Beebe is doing an excellent job; many favorable comments have been received on his program being broadcast over WJR every Wednesday night.

(4) *Proposed Program of Examination of High School Students.*—C. D. Barrett, M.D., Health Commissioner of Ingham County, entered the meeting at this point. He presented a plan for examination of high school students preliminary to a course of training in school to "harden" the students for future service in the armed forces. It was felt by this committee that such examinations at this time would necessarily be incomplete (blood count, urinalysis and complete physical examination), in view of the shortage of physicians, and the fact that most school children have received such examinations prior to their entrance into school, and following it, but it was the consensus of opinion

of this committee that wherever and whenever it is possible to secure physical examinations of all pupils in strenuous exercise, this should be done.

(5) *Group Disability Insurance.*—The Committee recommended that action on a group disability insurance program be postponed until after the County Secretaries' Conference in Lansing, January 24, and a consensus of opinion on the subject be obtained from the secretaries at that time.

(6) *Postgraduate Work After the War.*—This was referred to the Postgraduate Education Committee, for further study and an early report to the Council.

Respectfully submitted,

W. H. HURON, M.D.
R. J. HUBBELL, M.D.
A. H. MILLER, M.D.
P. A. RILEY, M.D.

7. (b) *The Finance Committee report* was presented by V. M. Moore, M.D., Chairman; also the budget estimates for 1943. Dr. Moore recommended that if the Industrial Health Clinic scheduled for April 8, 1943, should cost in excess of $200, earmarked in the Industrial Health Committee's budget for this purpose, the additional sums needed could be charged against the Cancer Committee budget up to a maximum of $200, if necessary, and that this has the approval of the chairman of the Cancer Control Committee.

This report was *referred to the Publication Committee:*

ANNUAL REPORT OF FINANCE COMMITTEE—1942

(1) *Roll Call.*—The meeting of January 15, 1943, was called to order in Parlor C of the Statler Hotel, Detroit, at 8:15 p.m. by V. M. Moore, M.D., Chairman. Those present: Drs. Moore, P. L. Ledwidge, R. S. Morrish and W. E. Barstow; also Secretary L. Fernald Foster, M. D. Absent: L. J. Johnson, M.D. Doctors H. H. Cummings, A. S. Brunk, C. R. Keyport and B. R. Corbus also came into the meeting.

(2) *Bills Payable* were presented, including expenses of the Executive Secretary, checks for postage and $400.00 to the Joint Committee on Health Education (out of its 1942 unexpended budget allotment). Motion of Drs. Barstow-Ledwidge that these be approved. Carried unanimously.

(3) *Ernst & Ernst Report.*—The report of the Ernst & Ernst audit for 1942 was studied and approved, motion of Drs. Ledwidge-Morrish. Carried unanimously.

(4) *Financial Picture for 1943.*—It was estimated there will be 3,630 dues-paying members at $12.00, totaling $43,560.00. Less the allocation to JOURNAL of $5,445.00, the total will be $38,115.00 for society activity, with interest and miscellaneous items totaling $38,365.00. It is estimated there will be a shortage of income this year over last year of about $8,000.00, due to nonpaying military members.

(5) *Technical Exhibit for 1943.*—It was reported that the technical exhibit space is all under contract. While there is a reduced number of spaces this year, we trust the meeting will be self-sustaining.

(6) *Secretaries' Expenses.*—The expenses of the Secretary and of the Executive Secretary were authorized to be continued as in 1942.

(7) *Consideration of Budget.*—(a) JOURNAL items: these were considered and approved. (b) MSMS items were studied, The completion of the integration of the MSMS postgraduate program during 1943 in Wayne County *will require* an increase in the Postgraduate Committee budget of from $500 to $700. It was moved by Drs. Ledwidge-Morrish that the budget as revised be submitted to the Council.

(8) *Springer Resolution.*—On motion of Drs. Morrish-Ledwidge, the following statement was adopted:

"The resolution to raise a fund to educate children of certain physicians by a contribution of $1.00 per member per year until an adequate fund has been raised has been considered. It will be recalled that the Committee on Resolutions of the House of Delegates (A. E. Catherwood, M.D., chairman) voted against the resolution but asked that it be referred to the Finance Committee of The Council for further consideration."

This committee would quote the Constitution of the Society, Article 2, as follows: "Purpose:

Section 1. The purposes of this Society are to promote the science and art of medicine, the protection of the public health and the betterment of the medical profession, and to unite with similar organizations in other States and Territories of the U. S. to form the American Medical Association."

It is our considered opinion that while the motive behind the resolution is laudable, provision for such activity is not specified in the Constitution and we therefore cannot recommend its adoption.

Respectfully submitted,

V. M. MOORE, M.D.
W. E. BARSTOW, M.D.
P. L. LEDWIDGE, M.D.
R. S. MORRISH, M.D.

7. (c) The *Publication Committee* report was presented by R. C. Perkins, M.D., Chairman, and *referred to the County Societies Committee:*

ANNUAL REPORT OF PUBLICATION COMMITTEE—1942

(1) *Roll Call.*—The meeting of January 15, 1943, was called to order by Chairman R. C. Perkins, M.D., in the Statler Hotel, Detroit, at 8:30 p.m. All members of the committee were present (Drs. Perkins, Beck, DeGurse, Stryker, Umphrey); also Acting Editor Haughey and Executive Secretary Burns. Also present for a portion of the meeting were President Cummings, Council Chairman Brunk and Past President Corbus.

2) *Budget Estimates for* JOURNAL *for 1943.*—These were studied. During discussion, motion was made by Drs. Umphrey-Beck that the Publication Committee recommend to The Council that Wilfrid Haughey, M.D., be offered the editorship of THE MSMS JOURNAL for the coming year at the same salary and expense account ($1,200 salary and $900 expense account). Carried unanimously.

The budget estimates were revised in several items so that the total income and total expense amounted to $18,350. Motion of Drs. DeGurse-Stryker that the budget estimates for THE JOURNAL, 1943, as amended, be approved and referred to the Finance Committee. Carried unanimously.

(3) *Editor's Annual Report* was presented by Dr. Haughey. Motion of Drs. DeGurse-Beck that the report be received and respectfully referred to The Council for its approval. Carried unanimously.

(4) *Advertising Matters.*—The annual rebate of the CMAB amounted in 1942 to $1,102.56. The committee recommended that the CMAB be commended for its excellent work during the past twelve months.

(b) Color inserts: The cost of these inserts was discussed and the committee recommended, on motion of Drs. Stryker-Umphrey, that the 3-page rate be retained, subject to the recommendation of the CMAB. Carried unanimously.

(c) The acceptance of advertising of products, not as yet accepted by the AMA Councils, was discussed. Motion of Drs. Umphrey-Beck that these prospective advertisements be not accepted in the MSMS JOURNAL until definite standards concerning them are established by the AMA Councils. Carried unanimously.

(5) Encouragement to MSMS members to contribute articles to their JOURNAL. The committee recommended additional encouragement, since not too many papers

are being received from Michigan men. The committee felt that outstanding papers read before the Wayne County Medical Society and other county societies, as well as those presented through the stimulation of the Foster Foundation might well be considered. Further, that articles on medical history be encouraged, and that radio talks presented by the MSMS Radio Committee also be utilized. It was recommended that the Editor write an editorial on material or articles that would be welcome in the MSMS JOURNAL, suggesting subjects, in order to encourage writers from the Michigan profession.

(6) *Problem of Frequent Changes of Address.*—This was presented and thoroughly discussed. The problem arose mainly from physicians in military service who are being transferred frequently during the course of a year. Perfect tabulation in THE JOURNAL office would require the services of one extra full-time employe. Motion of Drs. Umphrey-Stryker that, if information is received from the postal authorities that shipments of mail to foreign countries shall be discontinued, then the MSMS JOURNAL shall not be forwarded to members abroad. Carried unanimously.

President Cummings felt that THE JOURNAL should be sent to the last permanent address of the members in military service, in which Dr. Umphrey and other members concurred. Motion of Drs. Beck-Stryker: after notification in a JOURNAL editorial and in the Secretary's Letter to all members, the MSMS JOURNAL be sent to all men in military service, addressing same to the last permanent address; if no permanent address is furnished, THE JOURNAL be discontinued inasmuch as the copies are lost. Carried unanimously.

The Committee recommended that the executive office send a final notification (form letter) together with the postoffice notification to the military member at his last-known address, as first-class mail, when multiple changes of address were received.

(7) *Publication of Information* on number of physicians available for civilan needs. This correspondence with Procurement and Assignment Service and Morris Fishbein, M.D., was presented, discussed and ordered filed.

(8) *Requests for Journals, as Exchanges.*—The Committee approved exchanges with the *New Orleans Journal, Urological and Cutaneous Review.* It disapproved extra exchange journals to Georgia, in conformity with its policy of saving costs.

Respectfully submitted,

ROY C. PERKINS, M.D.
O. O. BECK, M.D.
T. E. DEGURSE, M.D.
O. D. STRYKER, M.D.
C. E. UMPHREY, M.D.

7—(d) The report of the Chairman of the *Special Committee on Integration of Postgraduate Programs* was presented by C. E. Umphrey, M.D., Chairman, and *referred to the County Societies Committee:*

REPORT ON INTEGRATION OF POSTGRADUATE PROGRAMS

You will recall that at the November meeting of the Executive Committee a resolution was presented from the Wayne County Medical Society for information on the State Society's financial program referring to the fact that some activities such as postgraduate medical education which have state-wide application are financed locally in Wayne County. As a result of the discussion on that communication, a special committee as listed below was appointed to study the matter, to interview all interested parties, and to report back to The Council at its meeting of January 16-17, 1943.

Your subcommittee chairman begs to report that he met with the Committee on Postgraduate Medical Education at its regularly scheduled session in Detroit, December 2. At that time Dr. Bruce explained in detail the background of postgraduate medicine in Michigan and the accomplishments of the past and present which have resulted most favorably in our holding front rank in this field throughout the nation. The Wayne County situation was outlined to the Committee with particular reference to the Continuation School of Medicine, which began in 1939 and during the succeeding three years had a total enrollment of 923 by over 400 individuals. Thirty-six courses were offered the first semester; sessions were held weekly. Subjects taught included: general medicine, pediatrics, syphilology, dermatology, physiotherapy, neurology, clinical interpretation of laboratory procedures, tuberculosis, and contagious diseases. The enthusiasm and confidence shown stimulated expansion and development. Other courses were: electrocardiography, allergy, diabetes, diseases of chest and heart, gastro-enterology, industrial medicine and surgery, diseases of bones and joints, clinical examination of the heart, review of medical literature, anatomy, and first aid. The cost of operating the Continuation School of Wayne County was about $700 per year.

The Committee was requested to consider recommending an appropriation by the State Society of about that amount to carry on the established good activities in the Wayne County area. It was felt that this would be a suitable and reasonable expenditure inasmuch as the State Society has offered nothing in Wayne County along this line and its financial experience per capita outside of Wayne County indicates that the Wayne County Continuation School has been economical in its operation. The matter was discussed at great length by the Committee but no recommendations were made.

A communication later was sent out by Dr. Bruce to the members of the Committee in which your chairman was misquoted to the effect of having reported that the Continuation School of Wayne County would be forced to close for financial reasons unless it secured an appropriation from the State Society. It has been reported that this misquotation since has been corrected by Dr. Bruce in a letter to the members of the Committee on Postgraduate Education of the Michigan State Medical Society and to Dr. Brunk, Chairman of The Council. The facts are that because of the exigencies of wartime, with shortage of physicians, difficulties of transportation, et cetera, the Continuation School is not offering any special courses in addition to those held at the Wayne University College of Medicine and in the hospitals.

Your chairman has had many informal conversations with various interested people, some of whom have taken an active part in the postgraduate picture during recent years. He has not attempted to review the entire postgraduate situation throughout the state because the Committee did not see clearly the necessity of doing so, and also because an exhaustive survey did not seem to pertain to the specific request made originally by the councillor from Wayne.

A meeting was held January 14, 1943, called by the Advisory Council of the Continuation School of Wayne County. Those present were Drs. Ralph H. Pino, W. W. MacGregor, C. E. Umphrey, Harry F. Dibble, David Sugar, M. Raymond Collings, A. P. Biddle and F. Yonkman.

The Committee recommended that the request for an appropriation of $700 per year placed by Dr. Umphrey before The Council and the Committee on Postgraduate Education receive favorable consideration and be granted and that this figure be increased later in keeping with the augmented program anticipated when the Continuation School of Medicine resumes activity at the end of the war.

Furthermore, the Committee recommends that the Wayne County Postgraduate program be integrated with the State Postgraduate program and be published in full in the state brochure; furthermore, that if this be not done the Wayne County program will be catalogued and carried forward as an independent unit. The Com-

mittee makes these recommendations because, in view of the wealth of postgraduate material in Wayne County and the imperative need of a progressive program for the practitioners and with particular reference to the more than one thousand men who will be returning to the community from military service, the Committee regards it as a major responsibility to prepare now for a continuation program consistent with the opportunities and responsibilities.

Your chairman again wishes to offer for consideration the recommendation previously made to the Postgraduate Committee; namely, that The Council of the MSMS, in view of the splendid postgraduate program in Wayne County, set aside the sum of $700 annually at this time as a gesture of coöperation to encourage this necessary scientific effort augmenting the regular program of the Michigan State Medical Society.

Respectfully submitted,

C. E. UMPHREY, M.D., *Chairman.*

President Cummings commented on the report of Dr. Umphrey, reiterating that Wayne County has fine teachers, hospitals, clinical facilities, and physicians deeply interested in postgraduate work; that the WCMS voluntarily withdrew in 1939 from the MSMS Postgraduate program and since has conducted its own very fine program; that if the WCMS with all its valuable teachers and courses already organized would integrate with the MSMS program, no attempt would be made by the State Society's committee to dictate the Wayne County courses, but that direction must be placed in some group, in order that it may be responsible and report to the MSMS Council.

8. *Reports of MSMS Committees.—*

(a) *Joint Committee on Health Education Representatives'* report was presented by B. R. Corbus, M.D., Chairman, who stated that the *Detroit News* column had been discontinued due to lack of funds. Dr. Corbus gave the background and history of the Joint Committee, mentioning the excellent library of movies which the Joint Committee possesses. He recommended that the work of the Joint Committee be continued so far as talks and radio presentations are concerned, with the elimination of the *Detroit News* column, and that the MSMS continue to subscribe to the Joint Committee in a limited way. The report was referred to the Finance Committee.

President Cummings stated that the Joint Committee has done much good work and accomplished a great deal, and approved the recommendations of Dr. Corbus.

REPORT OF JOINT COMMITTEE ON HEALTH EDUCATION

The Joint Committee on Health Education has come of age. During these twenty-one years the State Society has been liberal in its contribution to its work. For several reasons, which I will later state, I, as chairman of the Joint Committee as well as chairman of the Representatives from the State Society, feel obligated to make to you a report, and to ask you for your advice as to the future.

If you will bear with me for just a few minutes I should like to give you a very brief history of the Joint Committee.

In 1921 Dr. Kay, then president of the State Society, with Dr. J. B. Kennedy and Dr. Angus McLean, met with President Burton and Drs. Huber and Cabot, to discuss the "development of a plan for a series of medical lectures to the laity" to be undertaken jointly by the Society and the University.

Earlier experimental effort had definitely indicated that the public in general was both apathetic and indifferent to instruction in matters of health hygiene. Dr. Burton was most sympathetic with the idea, and suggested that the University might justifiably use the machinery of the Extension Division for the dissemination of such information. In keeping with policy a campaign was planned which contemplated programs of health lectures disseminated in the school system of the state, and to all adult groups that could be interested in a crusade for better and more wholesome life.

A program as extensive as this would, so the founders thought, be of interest to other groups who similarly felt the need for lay health education. So such other units as the Detroit University (now Wayne), Michigan State College, the State Department of Health, and the Anti-Tuberculosis Society were invited to join in the movement. So came to be the Joint Committee on Public Health Education. From time to time other organizations were added to this unit until now our letter head carries the names of twenty-four such organizations.

The organization was headed by the president of the University until some six years ago. Since that time I have been the chairman. As we got going in this work the University became much interested, and for some years it paid the salary of a part time field man, gave us the part time services of Dr. Henderson, head of the Extension Division, and carried largely the expenses of operation.

In this period a special campaign was directed to the health education of the school child and in 1929-30, five hundred physicians appeared before audiences totaling 220 thousand.

It was at about this time that the *Detroit News* suggested that the committee undertake to conduct a Daily Health Column, and this has been and is being continued.

With the depression period the University was forced to withdraw the salary paid the field secretary, and the income from other sources was materially lessened, and in the period of 1932-35 our activities were limited to a curtailed Speakers' Bureau and the Health Column.

In 1935 Dr. Ruthven, as chairman, was asked to appoint a committee to see where we might advantageously enlarge the scope of the program, and to further consider the very important question of the financing of the work.

The committee appointed for the purpose of interpreting the needs which might be met by this committee, especially emphasized the need for the effectual presentation of matters of health to the school child. The results of our earlier experiment did not seem to fully justify the amount of work that was put into it. At this time a program was proposed to bring health education to the teacher that he, in turn, might present it to the child. This involved, of course, the development of curricular materials and it meant the establishment of a definite permanent curricular program in our schools of the state, to be presented by a teacher who had had some instruction in its presentation.

This quite ambitious program was presented first to the Department of Public Instruction and the Department of Health, which were enthusiastic about the idea, and then our problem was to see how it could be financed. From various sources we obtained liberal financial support, largely, but not entirely, from the Couzens Fund and the Kellogg Foundation. With this support we were able to hire a fulltime secretary whose part duty it was to promote public lectures and initiate our radio program, while, at the same time, a subcommittee composed of educators, health workers and doctors, was busy drawing up the curricula. In addition there were initiated conferences on health education at the different state teachers' colleges. These were the years of our greatest activity. In these years a number of bulletins were issued. "The Problem Solving Approach in Health Teaching" was one. "Experiences in Healthful Living," "Health Goals of the School Child," and a bulletin on which much work was put but which was never, in its entirety, released—"Mental, Social and Personal Hygiene, An Interpretation of Sex Education."

These bulletins were sent all over the United States,

and are still in demand. In their publication, in many instances, we were assisted by the State Department of Health.

So much for our past activities. I think you will see that the Joint Committee is a unique organization which is geared to do big things in the field of health education. However, as time has gone on, I am conscious of a lack of interest in the constituent units. As long as Dr. Pritchard lived he went along with us with very substantial contributions. Last year our only contribution, outside the Michigan State Medical Society, was one hundred dollars from the Hospital Association. It is true that many of these units have no funds to draw upon.

The Extension Division of the University furnishes the machinery for the dissemination of our radio programs and for the Speakers' Bureau, and the University seems to be willing to go on with this contribution. I think it may be said that no State Society health committee has as great an opportunity for successful operation as we have through our tie-up with the Extension Division, and no more sympathetic enthusiast than Dr. Charles A. Fisher, who is head of that division and who acts as secretary of the Joint Committee.

Respectfully submitted,
B. R. CORBUS, M.D., *Chairman.*

STATEMENT OF RECEIPTS AND EXPENDITURES, JOINT COMMITTEE
1941-1942

Receipts:		
Balance on hand July 1, 1941	$110.00	
Sale of bulletins	15.66	
Contributions—Medical Society	700.00	
Total receipts		$825.66
Expenditures:		
Postage	$ 48.00	
Pay Roll—speakers	520.00	
Office supplies	113.15	
(Publicity fund $64.03)		
Mimeographing	11.73	
Slides	3.50	
Parcel Post	.70	
Refund on bulletins (paid twice)	2.10	699.18
Balance on hand July 1, 1942		$126.48

RANGE OF HEALTH TOPICS DISCUSSED BY SPEAKERS
1941-42 and 1940-41

	1941-42	1940-41
Child Psychology	7	7
Child Growth and Development	15	20
Nutrition	4	
Mental Hygiene	15	39
Adolescence	2	
Child Health	4	10
Pre-School Child	1	3
Dentistry	2	4
Syphilis and Sex Education	4	4
Allergy	1	2
Physical Education	1	
Immunization		2
Psychiatry		1
Cancer Control		10
Preparation for Marriage		1
Juvenile Delinquency		2
General Health		3
Speech Correction		3
Totals	56	111

8—(b) The report of the *Cancer Committee* meeting of December 18 was presented by Wm. A. Hyland, M.D., and adopted on motion of Drs. Hyland-DeGurse. Carried unanimously.

8—(c) The report of the *Syphilis Control Committee* of December 20 was read by Secretary Foster. An extract of the Legislative Committee's minutes of January 14 meeting (Item 11) concerning the recommendations of the Syphilis Control Committee (in Item 4 of 12/20 minutes), was presented. Motion of Drs. Ledwidge-Perkins that the minutes of the Syphilis Control Committee, as amended by the Legislative Committee in its Item 11, be accepted with an instruction to the Syphilis Control Committee that the proposed amendments to the Premarital Examination Law be introduced into the Legislature by the State Department of Health, as an aid in their early passage. Carried unanimously.

8—(d) The report of the *Preventive Medicine Committee* meeting of January 7 was read by the Executive Secretary and accepted on motion of Drs. Huron-Barstow. Carried unanimously.

8—(e) The report of the *Legislative Committee* meeting of January 14 was read by the Executive Secretary. Dr. Keyport presented the new draft of a proposed amendment to the Medical Practice Act which would permit licensing of graduates of medical schools having telescoped courses.

A letter from the Wayne County Medical Society was read which contained a resolution re endorsement of persons who favor federalized medicine seeking public positions. Motion of Drs. Perkins-Stryker that the Legislative Committee report, except Item 6, be approved, was carried unanimously.

Referred to the Publication Committee were: (1) new draft of proposed amendment to Medical Practice Act; (2) WCMS Resolution re persons seeking public positions who favor federalized medicine.

8—(f) *Medical-Legal Report* concerning two cases was accepted on motion of Drs. Stryker-Perkins. Carried unanimously.

8—(g) Report on the *Industrial Medical and Surgical Clinic* being arranged by the Industrial Health Committee for April 8 in Detroit was presented and accepted.

Recess for Luncheon

SECOND MEETING

January 16, 1943—1:45 P.M.

9. *Report on Survey of Adequacy of Medical Care for Civilian Needs.*—The Executive Secretary presented the following digest of this survey made by county society secretaries covering seventy-seven counties, to January 15, 1943:

18 secretaries report clinical shortages of physicians in certain areas
9 secretaries report abnormal increase in population since 1940
66 physicians need to be re-located (60 general practitioners; 1 general surgeon; 1 industrial surgeon; 3 obstetricians, and 1 pediatrician)
In 29 areas needing 66 additional physicians:
375 physicians were practicing December 7, 1941; (no figures given by Wayne County)
262 physicians were practicing December 7, 1942; (no figures given by Wayne County)
132 physicians were called into service.
No report was filed by Secretaries of Cass, Gratiot-Isabella-Clare, Lapeer, and Washtenaw counties, as of January 15.

Motion of Drs. Perkins-Keyport-Haughey that the report be accepted and presented at the County Secretaries Conference of January 24 and published in THE JOURNAL. The survey was discussed by Drs. Ledwidge, Brunk, Miller, Foster. Motion carried unanimously.

A letter from S. W. Donaldson, M.D., Ann Arbor, re a survey of adequacy of medical care in the Willow Run district was read. President Cummings reported that the physicians of Washtenaw County are handling the situation satisfactorily and need no outside help.

10. *1943 Annual Meeting.*—Dr. Riley suggested the appointment of a Committee on Hotels to aid with the housing situation at the 1943 Postgraduate Conference on War Medicine in Detroit next September. Motion of Drs. DeGurse-Beck that the Chair be authorized to appoint a Committee on Hotels for the 1943 conference. Carried unanimously.

11. *"Labor and Industry."*—This magazine, the organ

of the Department of Labor and Industry, has requested an article on the survey of adequacy of medical care for civilians. Motion of Drs. Ledwidge-Barstow that such an article be authorized and forwarded from the President and Secretary of the Society, the story to indicate that a small number of physicians need to be re-located but that no need exists for the importation of out-of-state physicians in Michigan. The matter of relocation was discussed by Drs. Riley, Haughey and Foster. The motion was carried unanimously.

12. *Rehabilitation Program of Michigan State Board of Control for Vocational Education.*—The Executive Secretary reported that $10,000 of federal-state monies have been set aside for this experimental program in Michigan, to be used from January 1 to June 30, 1943. Michigan has been selected as the test state. The official release (VR-14) from George H. Fern, Director, stated:

"For the balance of this fiscal year physical restoration services, including medical care, surgical repair, physical therapy, and occupational therapy, are authorized for rehabilitation cases.

"This service may be granted under the following conditions:

(a) If it will assist the physically disabled to become employable.

(b) If recognized hospitals, doctors, physical therapists, and occupational therapists are used.

(c) If no other method of financing physical restoration service is available.

(d) If the expenditure in each case is reasonable in amount."

Discussed by Drs. Riley, Haughey, Huron, Ledwidge and Perkins. Motion of Drs. Ledwidge-Huron that committee of three be appointed to contact the State Board of Control of Vocational Education and to use its influence so that proper coöperation in this experiment be obtained. Carried unanimously. Those appointed on the committee were: P. L. Ledwidge, Chairman; R. C. Perkins; P. A. Riley.

13. *National Conference on Medical Service.*—Motion of Drs. DeGurse-Miller that the President, the Chairman of the Council, the Editor, and the Secretaries be authorized to attend this Conference in Chicago on February 14. Carried unanimously.

14. *Crippled-Afflicted Children Legislative Conference of January 8, 1943.*—The Executive Secretary reported on the proposed changes in the Afflicted and Crippled Child laws approved at this meeting, that a drafting committee (of which H. A. Miller, M.D., was the MSMS representative) had been appointed to present amendments to these Acts to the Legislature in February. The matter was discussed and the report was adopted on motion of Drs. Miller-Huron. Carried unanimously.

15. Progress report of Chairman of *House of Delegates Committee on Constitution and By-laws re Resolution concerning Emeritus Membership* for physicians attaining seventieth year, was presented and discussed by Secretary Foster and Drs. Miller and Huron. Motion of Drs. Haughey-Umphrey-Keyport that the progress report be accepted and that the Executive Office continue to coöperate with the Chairman of the Constitution and By-laws Committee (C. L. Hess, M.D.), in supplying him with membership and statistical data. Carried unanimously.

16. *Resignation of Councilor L. J. Johnson, M.D.*—President Cummings presented the resignation of Dr. Johnson, now in the Navy. Motion of Drs. DeGurse-Barstow that the resignation be accepted with regret. Carried unanimously.

A motion was made by Dr. Ledwidge and seconded by all that a letter be dispatched to Lt. Commander L. J. Johnson, M.C., USN, informing him that his presence at this meeting was missed, that his advice at past meetings of The Council was sincerely appreciated, and that The Council wishes him a satisfactory and medically-profitable experience in his new work and hopes that he may return to Michigan soon with Victory 'round his shoulders. Carried unanimously.

New Councilor—The President nominated Dean Myers, M.D., of Ann Arbor to fill the vacancy for the unexpired term. Motion of Dr. Morris, seconded by Drs. Barstow-Keyport, that the nomination of Dr. Myers be accepted and approved. Carried unanimously.

17. *Letter of thanks from Lieutenant Colonel H. A. Furlong, M.C.*—This letter from Dr. Furlong, recently resigned Director of the Michigan Council of Defense and of the Selective Service of Michigan, was read by the Executive Secretary, and ordered placed on file.

18. *Reimbursement from Procurement and Assignment Service.*—The Executive Secretary reported that neither the State Society nor any county medical society which had expended funds for Procurement and Assignment Service work has been reimbursed.

19. *Reports of individual councilors* on the condition of the profession in each Councilor District. These verbal reports were presented in detail by Councilors Barstow, Stryker, Perkins, Haughey, Beck, DeGurse, Morrish, Hubbell, Huron, Moore, Miller, Riley and Umphrey. A number of war casualties were reported. In general, the condition of the profession in all parts of the state is very good and few major problems exist.

Recess for Reference Committee Meetings

(To be concluded in March issue.)

Reading Notices

VITAMIN FILMS IN COLOR

During the past year the three 16-mm. silent motion pictures in color, describing certain vitamin deficiency diseases, which were made available by Eli Lilly and Company, Indianapolis, for showing before medical groups under sponsorship of a physician, have been in continuous demand. One film deals with deficiency of thiamine chloride (beriberi), another with nicotinic acid deficiency (pellagra), and the third with ariboflavinosis. To meet increasingly frequent demands for the films, additional new prints have been placed in circulation and are now ready for loan. The major part of all films concerns the clinical picture presented by the patient with reference to treatment by diet and specific medication. They do not contain advertising of any description, nor is the name of Eli Lilly and Company mentioned.

WAR PRODUCTION BOARD ORDER AFFECTS VITAMIN CAPSULES

To conserve vitamin A supplies during wartime, WPB order L-40 limits the content of capsules to 5,000 vitamin A units.

In compliance with this order, capsules of Mead's Oleum Percomorphum 50% with Viosterol now contain 83 mg. of oil, equivalent to 5,000 vitamin A units and 700 vitamin D units per capsule.

The new size capsule is now supplied in boxes containing 48 and 192 capsules—about twice the number of capsules without increase in price.

ACUTE CONTAGIOUS CONJUNCTIVITIS

In order that industry may be on guard, the Michigan Department of Health is taking this means of relaying information concerning an unusual type of eye infection. These cases first occurred at Pearl Harbor in the summer of 1941 and in the shipyards in Oregon the following October. While most of the cases have been confined to industrial workers, a few cases have occurred in family members.

Recently the United States Public Health Service reported the occurrence of this disease in several war plants throughout the country. Several such cases have occurred in Michigan during the past two or three weeks.

We ask your coöperation in relaying the following information and collaborating with your plant physicians in this problem.

An excerpt from the United States Public Health Service report is as follows:

Sporadic epidemics of conjunctivitis are occurring in war plants. Similar epidemics were confined to the West Coast last year, but recently as many as three hundred cases have appeared in a single plant in the East. The infection does not appear to be of occupational origin, but is supposed to be by person to person transmission.

A virus has been isolated in the East which corresponds to that believed to be responsible for the Western epidemic. Average duration of the disease, in untreated cases, is three to four weeks. There is an acute stage in which there is swelling of the eyelids and enlargement of the small sacs of the membrane which lines the eyelids, especially on the upper lid. Eyes appear inflamed and "bloodshot." In typical cases there is swelling of the glands in front of the ear.

Following such infection, parts of the transparent covering of the eyeball may become impervious to light. The corneal opacity may last as long as six months, and in some cases, vision of workers may suffer permanent impairment.

Onset of the infection usually is in but one eye; less than one-fourth the infections begin in both eyes. The severe reactions produced in the course of the disease necessitate the workers' absence from the job for as long as a week or ten days in cases under treatment.

Workers are losing time from important war effort because of conjunctivitis; it is important to prevent the spread of this infection to other industries. Your cooperation is sought.

Preventive Measures

1. Isolation of the patient as soon as symptoms are noted, with proper advice concerning preventive measures to all contacts.
2. Aseptic technique in handling eye cases.
3. Sterilization of eye droppers and eye instruments.
4. Sterilization of eye treatment solutions.
5. Sterilization of eye goggles, et cetera.

It would be appreciated if prompt notification be made to the Michigan Department of Health of cases occurring in your vicinity.

ADEQUACY OF MEDICAL SERVICE FOR CIVILIANS

The report on the Survey of Medical Service Available for Civilians, conducted through county medical society secretaries, indicates that about three score physicians, at most, need to be relocated in Michigan to give service in all localities. Based on other surveys of similar nature (such as that made by the Procurement & Assignment Service) this reported need is high.

Reports from Seventy-nine (79) Counties

The report for seventy-nine counties, received to January 21, 1943, is as follows:

18 secretaries report critical shortages of physicians in certain areas.

10 secretaries report abnormal increase in population since 1940.

66 physicians need to be relocated (60 general practioners; 1 general surgeon; 1 industrial surgeon; 3 obstetricians and 1 pediatrician).

In 29 areas needing 66 additional physicians,

375 physicians were practicing on Dec. 7, 1941 (Wayne County not included)

262 physicians were practicing on Dec. 7, 1942 (Wayne County not included)

132 physicians were called into service (Wayne County not included)

Publicity on the manner in which the medical profession is meeting military, industrial, research, and civilian needs during wartime should be spread by members of the medical society, to counteract unreliable propaganda.

Compilation of the survey, made by the State Society, indicates that no avalanche of physicians from other states is needed in Michigan. Only a few score must be relocated in this state in order to cover overpopulated localities and to bring to all our people the service they require. The medical profession is most desirous that the type and quality of medical practice which has made Americans the healthiest people in the world will be continued.

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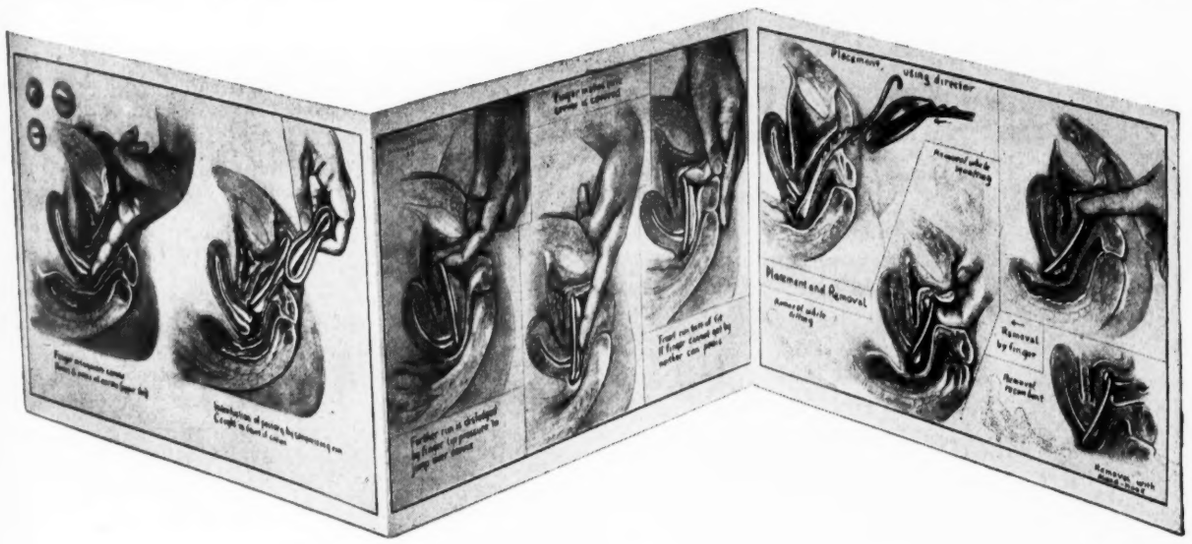

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MICHIGAN'S DEPARTMENT OF HEALTH

H. ALLEN MOYER, M.D., Commissioner, Lansing, Michigan

UNDULANT FEVER INCIDENCE IN 1942 DOUBLE THAT OF TYPHOID

Reported cases of undulant fever in Michigan in 1942 were almost twice as many as reported typhoid cases, the Michigan Department of Health points out in a warning against the use of unpasteurized milk. Ten years ago, typhoid fever was about 12 times as prevalent as undulant fever.

STATE'S BIRTH TOTAL HIGHEST IN 1942; INFANT MORTALITY LOWEST

A record total of 124,000 births during 1942 in Michigan is coupled with an all-time low in deaths of infants under one year—an estimated rate of 36.18 per 1,000 live births—on the basis of reports for the first ten months compiled by the Michigan Department of Health.

The 1942 birth total represents a gain of 16,500 over the 1941 figure.

The state's infant mortality rate in 1900 was 159.08 per 1,000 live births.

EPIDEMIC KERATOCONJUNCTIVITIS NOW A REPORTABLE DISEASE

At a meeting of the State Council of Health, January 7, 1943, epidemic keratoconjunctivitis was designated as a reportable disease. This means that all cases or suspected cases shall be reported to the local health officer within 24 hours following diagnosis.

Keratoconjunctivitis is probably caused by a virus which is transmitted from person to person by direct or indirect contact. This disease, commonly called virus conjunctivitis, occurs in all ages and occupations but is more common in adults working in industry.

The condition in its early stages is difficult to diagnose and must be differentiated from all other types of acute conjunctivitis. The diagnostic criteria are:

1. Severe conjunctivitis.
2. Edema of the loose tissues.
3. Profuse tearing—frequently blood stained.
4. Preauricular and follicular lymphadenopathy.
5. Negative eye cultures and smears.
6. Late development of corneal opacities which do not stain with fluorescein.

The following recommendations are suggested to aid in the control of this disease:

1. Early recognition.
2. Isolation and exclusion from work of all infected individuals.
3. Instruction of patients about the communicability of the disease.
4. Careful communicable disease technique by physicians, nurses and first-aid workers in handling of all cases and suspected cases.
5. Immediate reporting to local health authorities.

BIRTH RECORDS

Requests for more than 115,000 copies of birth records which establish proof of citizenship were received by the Michigan Department of Health during 1942.

Errors made in reporting births occurring in Michigan to the Department cost taxpayers an estimated $15,000 last year. Correction of records is the full-time job of eight clerks. There is a tidy bill for paper, envelopes and postage.

NEW INDUSTRIAL HYGIENE DISTRICT OFFICES OPENED

District offices of the Department's Bureau of Industrial Hygiene have been opened in the Kalamazoo City-County Health Department, serving Kalamazoo, Van Buren, Berrien, Cass and St. Joseph counties, and in the Washtenaw County Health Department in Ann Arbor, serving Washtenaw, Jackson, Hillsdale and Lenawee counties.

BLOOD PLASMA RESERVES

Plasma reserves are now available in every civilian defense region for use in the event of casualties resulting from enemy action or sabotage.

The Regional Medical Officer will keep all Chiefs of EMS, hospitals, and Red Cross Disaster Relief Chairmen informed concerning the amount and distribution of plasma reserves available in the state and how localities may secure additional supplies in emergencies.

In cities where reserves are stored they may be obtained by hospitals through the local Chief of Emergency Medical Services. If a community is without plasma or if its supplies are depleted, the local Chief of EMS may obtain additional plasma in emergencies from the State Chief of EMS.

These instructions should not be construed to prevent the use of this plasma for life-saving purposes in any disaster. If OCD plasma is used in non-war related incidents, its use may be considered as a loan, and arrangements may be made later for its replacement.

DOCTOR ANDREWS RESIGNS

F. T. Andrews, M.D., resigned as director of the Bay County and Bay City Health Departments, effective February 1, 1943. Dr. Andrews has accepted a position in industrial surgery with the Fisher Body Division of the General Motors Corporation in Lansing.

MICHIGAN'S POSTGRADUATE INDUSTRIAL MEDICAL AND SURGICAL CONFERENCE

April 8, 1943

Rackham Memorial Building

Detroit

Sponsored by

The Michigan State Medical Society

In coöperation with

The Department of Postgraduate Medical Education, University of Michigan

Tentative Program

Morning

General Chairman: Kenneth E. Markuson, M.D., Lansing, Chairman, Committee on Industrial Health, Michigan State Medical Society

9:30 Address of Welcome

Presiding Chairman: H. H. Cummings, M.D., Ann Arbor, President, Michigan State Medical Society

9:40-10:10 "The Present Status of Medical Programs in War Industries."

10:10-10:40 "The Employment of Older Workers."

10:40-11:10 "The Employment of Women in Industry."

11:10-11:40 "Industrial Hygiene and the War Effort."

11:40-12:10 "Industrial Illness and Disability Analysis."

12:15-12:45 Luncheon—Rackham Memorial Dining Room

12:45- 2:00 Round Table Discussions

Rackham Memorial Conference Rooms

1. "Heart Diseases in Industry"
2. "Traumatic Eye Injuries and Infections"
3. "Dermatitis in Industry"
4. "Back Injuries—Medical-Legal Complications"
5. "Management of the More Common Industrial Fractures"

Afternoon

Presiding Chairman: Clarence D. Selby, M.D., Medical Consultant, General Motors Corporation, Detroit

1:45-2:15 "Industrial Dermatoses"

2:15-2:45 "Mental and Psychological Problems in Industry"

2:45-3:15 "Pathology and Surgical Management of Acute Head Injury"

3:15-3:25 Recess

3:30-4:00 "Surgical Repair of Traumatic Injuries of the Head"

4:00-4:30 "Management of Burns"

4:30-5:00 "Hematological Manifestations of Toxic Exposures in Industry"

6:30 Banquet—Rackham Memorial Building

ALL SPEAKERS WILL BE ANNOUNCED IN THE MARCH MSMS JOURNAL

COUNTY AND PERSONAL ACTIVITIES

100 Per Cent Club for 1943

Barry County—H. S. Wedel, M.D., Secretary
Macomb County—D. Bruce Wiley, M.D., Secretary
Manistee County—C. L. Grant, M.D., Secretary
Ontonagon County—W. F. Strong, M.D., Secretary

The above county medical societies have certified 1943 dues for every member of their respective societies, to be the first 100 per cent paid-up counties for this year. Michigan State Medical Society dues for 1943 are $12.00.

A membership record was established in 1942 when the total number of Michigan State Medical Society members reached an all-time high of 4,714.

A tip to the people: Preserve your most valuable asset: *Health,* through American Medicine.

* * *

Carl Arksey, Lansing, is the artist who photographed the Michigan State Capitol, which appeared on the cover of the January number of THE JOURNAL.

"In the aged, the mouth becomes the nutritional barometer of health."—EDWARD L. TUOHY, M.D., JAMA, Jan. 2, 1943.

* * *

Wm. J. Burns, Executive Secretary of the Michigan State Medical Society, has been appointed a member of the Public Relations Committee of the State Bar of Michigan.

* * *

In Australia: Lieut. Walter G. Neeb, formerly of Detroit, writes from Australia: "Need I mention the pleasure each copy of the Michigan State Medical Society Journal brings to me in this isolated portion of Australia. Thanks much."

* * *

H. B. Elliott, M.D., Flint, has accepted a position in the Department of Surgery at the College of Physicians and Surgeons and Presbyterian Hospital of Columbia University, New York. He served as secretary for the Genesee County Medical Society and Hurley Hospital Staff.

* * *

Lt. Colonel Harold A. Furlong, M.C., U.S.A., resigned as Administrator of the Michigan Council of Defense and as State Medical Officer of the State Selective Service on December 30, 1942, after two years'

service in Lansing. Colonel Furlong has been assigned to Carlisle Barracks, Carlisle, Pennsylvania.

Best wishes, Colonel Furlong, for success and satisfaction in your new work.

* * *

The Manistee County Medical Society sponsored three newspaper insertions of a "Notice to the Public" urging that the people coöperate with physicians in the matter of requests for home visits, office calls, and night calls, during the present emergency. Reprints of the newspaper announcements were distributed to members of the Society for circularization to patients. The response has been most favorable.

* * *

Clarence D. Selby, M.D., Detroit, was guest speaker at the Fifth Annual Conference on Industrial Health sponsored by the Council on Industrial Health of the AMA, Palmer House, Chicago, January 11-13, 1943. Dr. Selby spoke on "Procurement and Training of Professional Personnel for Industrial Health Service" and on "Why Do Employees Stay Away from Work and What Can We Do About It?"

* * *

MSMS 1943 Annual Session. The 1943 Postgraduate Conference on War Medicine—the 78th annual meeting of the State Society—will be held in Detroit at the Statler Hotel, September 22, 23, 24. Twenty-two (22) out-of-Michigan guest-essayists will be on the program.

During wartime a three-day refresher course of stellar quality, covering all phases of medical practice, must be welcomed by the busy and harassed practitioner. *Attendance should be a MUST!*

* * *

The Professional Liaison Committee, composed of three members each from the Michigan State Medical Society, the Michigan State Dental Society, and the Michigan State Pharmaceutical Association is as follows: A. F. Jennings, M.D., Detroit; W. H. Boughner, M.D., Algonac; E. L. Chapman, M.D., Detroit; E. J. Garlock, D.D.S., Lansing; C. J. Wright, D.D.S., Lansing; Fred J. Henry, D.D.S., Grand Rapids; Mr. A. J. Meyer, Detroit; Mr. Jack Webster, Detroit; Mr. Tracy Laubscher, Lansing.

* * *

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The G. A. Ingram Company, Detroit, Michigan
The "Junket" Folks, Little Falls, New York
The Kellogg Company, Battle Creek, Michigan
A. Kuhlman & Company, Detroit, Michigan

The above ten firms were among the exhibitors at the 1942 MSMS annual meeting in Grand Rapids and helped make possible for your enjoyment one of the outstanding state medical meetings in the country. Remember your friends when you have need of equipment, medical supplies, appliances or services.

* * *

Voluntary Relocation. Any physician who is seeking opportunity and really is willing to be relocated for service, either in industry or in over-populated areas,

and who has not been declared essential to his present locality, may send his name to the Michigan Consultant to the War Manpower Commission, P. R. Urmston, M.D., Davidson Building, Bay City (Telephone: Bay City 2-5421). This is necessary if the medical profession is to be able to solve its service problem adequately and promptly. It is desirable that better distribution of physicians be obtained on a *voluntary* basis. Doctors of Medicine over the age of 45 who wish to participate in the war effort and who are seeking good locations are invited to take advantage of this opportunity.

* * *

The Michigan Pathological Society held its annual meeting on December 12, 1942, at the Henry Ford Hospital, Detroit. The scientific program had been arranged in the form of a seminar with all members having microscopic slides and histories of the cases which were presented. The subject of the seminar was, "Lesions of the Small Intestine." Cases were presented by Drs. D. H. Kaump, F. W. Hartman, G. L. Bond, C. E. Black, J. G. Christopher, L. W. Walker, H. R. Prentice, and D. C. Beaver. The newly elected officers for 1943 are: President, H. R. Prentice, Kalamazoo; President-elect, D. C. Beaver, Detroit; Secretary-Treasurer, S. E. Gould, Eloise; Councillors: E. H. Norris, Detroit, and H. E. Cope, Lansing.

The next meeting, scheduled at the Grace Hospital, Detroit, on February 13, will be a symposium on "Lesions of the Skin."

* * *

Localities Urgently Needing Doctors of Medicine. According to incomplete returns from the Survey of Medical Service Available for Civilians, conducted through county medical society secretaries, the following localities need additional medical service. Physicians willing to be relocated are invited to investigate the opportunities in these cities and counties:

Augusta
Belding
Climax
Clinton County
Clio
Delton
Eaton Rapids
Ferndale area
Fulton
Gladwin County
Hillman
Homer
Iron County
Ludington
Mendon
Missaukee County
Monroe
Mount Morris
Muskegon
New Baltimore area
Royal Oak
Sault Ste. Marie, and Chippewa Co.
Schoolcraft
Swartz Creek
Tecumseh
Tekonsha
Vicksburg
Wexford County

* * *

Keep a Narcotic Record for Your Protection. All practitioners shall keep a daily record showing the kind and quantity of narcotics dispensed or administered, the name and address of each person to whom dispensed or administered, the name and address of the person upon whose authority and the purpose for which dispensed or administered, according to Article 177 of Federal Narcotic Regulations No. 5. No special record

form for the use of practitioners is prescribed by the Federal Regulations.

This record, when balanced against the inventory submitted by the practitioner at the time of his latest registration, plus the total of subsequent purchases, and minus the stock on hand at any given time, affords a ready means of accounting for the practitioner's dispensing of narcotic drugs over the period. He can readily determine, for instance, whether there may have been a loss due to theft of part of his stock. In this connection, the practitioner is urged to exercise unusual care in safeguarding his stock of narcotic drugs as the drastic shortage of narcotics in illicit channels has resulted in attempts on the part of drug addicts and peddlers to pilfer supplies of the drug from the stocks of practitioners and druggists.

* * *

The MSMS Radio Committee is sponsoring an interesting series of medical broadcasts, in coöperation with the University of Michigan Extension Division and Radio Station WJR.

The medical series are broadcast on Wednesdays, 10:30 p.m., over Station WJR. The list of talks follows:

Nov. 11—Dr. Carl A. Moyer, Assistant Professor of Surgery, Topic: Physiological Problems Pertaining to the War.

Nov. 18—Dr. Maurice Seevers, Professor of Pharmacology and Chairman of that Department, Topic: The Sulfa Drugs.

Nov. 25—Dr. George Ramsey, Resident Lecturer in Epidemiology, Topic: Epidemics in Time of War.

Dec. 2—Miss Rhoda Reddig, Professor of Nursing and Director of School of Nursing, Topic: Nursing During the War.

Dec. 9—Dr. Howard H. Cummings, Director of Postgraduate Medicine, Topic: The Effect of the War upon Medical Service in Michigan.

Dec. 16—Dr. Ralph Pino, Editor, "Detroit Medical News," Topic: What Michigan Is Doing through Health Insurance for the Community.

Jan. 6—Dr. Raymond W. Waggoner, Professor of Psychiatry and Chairman of that Department, Topic: Psychiatric Problems of the War.

Jan. 13—Dr. Frank N. Wilson, Professor of Internal Medicine, Topic: Medical Research in South America.

Jan. 20—Dr. Harold Falls, Assistant Professor Ophthalmology, Topic: The Care of the Eyes of Children with Special Reference to Amblyopia.

Feb. 10—Dr. Henry Ransom, Associate Professor of Surgery, Topic: Until the Doctor Comes.

Feb. 17—Dr. Charles F. McKhann, Professor of Pediatrics and Communicable Diseases, and Chairman of that Department, Topic: War Babies.

Feb. 24—Dr. Frederick A. Coller, Professor of Surgery and Chairman of that Department, Topic: War Injuries, Treatment of Wounds. Cuts, Burns and Shock.

March 3—Captain Donald Leonard, Michigan State Police, Topic: Emergency Medical Service in Michigan.

March 10—Dr. Herman Riecker, Civilian Health in Michigan Defense Areas.

IN MEMORIAM

DIED IN SERVICE

Lieutenant Stuart Terry of Pontiac was born October 5, 1907, in Owensboro, Kentucky, and was graduated from the University of Michigan Medical School in 1933. He interned at Harper Hospital and later was associated with the Michigan Mutual Hospital, Detroit. For a time he served as resident physician at Pontiac State Hospital and at St. Joseph's Mercy Hospital, Pontiac. In 1936, he went into private practice at Pontiac. Lieutenant Terry received his commission on June 17, and received his preliminary training at the Great Lakes Training Station and left for overseas last September. His death was caused by drowning in New Zealand on December 20, 1942.

Warren L. Babcock, of Detroit, was born March 14, 1873, in Eden, New York, and was graduated from the College of Physicians and Surgeons, Baltimore, Md. After serving as a surgeon at the Ogdensburg (New York) Hospital for the Insane and the Old Soldiers Home at Bath, N. Y., for several years, Dr. Babcock came to Detroit in 1904 as superintendent of the Grace Hospital. He resigned from his directorship at Grace Hospital in June, 1937, and accepted the position of treasurer of the board. He was past president and treasurer of the Michigan Hospital Association; past president of Wayne County Medical Society and past president of the Detroit Philatelic Society. He served overseas for two years in the First World War with the rank of colonel in charge of Base Hospital Number Six. He died in St. Petersburg, Florida, on December 27.

T. E. Camper of Owosso was born in 1897 and was graduated from the University of Pennsylvania in 1924. He began his practice in Delaware and also practiced in Maryland before his appointment as director of the Iron County Health Department in 1937. He remained in Iron River until the fall of 1940, when he was appointed health director of Owosso County. Before going to Owosso he took postgraduate work in public health at the University of Michigan, Ann Arbor. He died January 1, 1943.

Jean Vernier Radcliffe of Detroit was born in St. Clair County in 1874 and was graduated from the American Medical Missionary College at Chicago in 1900. She was an assistant professor of obstetrics and gynecology for five years at the college. In 1905 Dr. Radcliffe came to Detroit to enter private practice. She was an honorary member of the Wayne County Medical Society and an honorary life member of the Blackwell Medical Society. She died December 21, 1942.

Charles H. Rupprecht of Calumet was born in 1869 at Calumet and was graduated from the Michigan College of Medicine and Surgery, Detroit, in 1895. Dr. Rupprecht began his practice in Calumet where he remained until his death. He was known

and highly esteemed throughout the Copper Country. He died December 8, 1942.

Robert Weirich of Marcellus was born in 1895 in Cincinnati, Ohio, and was graduated from Northwestern University Medical School in 1928. He interned in Wesley and Cook County hospitals, Chicago. He was on the staff at the State Hospital at Kalamazoo for a year following his graduation, and then went to Marcellus in 1930 where he established a general practice. Dr. Weirich served in the signal corps of the U. S. Army during World War I. He died December 25, 1942, in St. Luke's Hospital, Chicago.

THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

NASAL MEDICATION. A Practical Guide. By Noah D. Fabricant, M.D., M.S., Associate in Laryngology, Rhinology and Otology, University of Illinois, College of Medicine. Baltimore: The Williams and Wilkins Company, 1942. Price, $2.50.

Dr. Fabricant has made a critical and very thorough analysis of Nasal Medications. First he reviews the anatomy of the nose and accessory sinuses, then an exhaustive study of physiology, including the action of drugs on the cilia, the mucous flow and the sinus linings and the pH concentrations with their meaning. The pathological physiology of nasal diseases is presented. With this background the uses and actions of the whole nasal medicinal armamentarium is given and discussed, giving reasons for favoring certain procedures and discarding others. Authorities are quoted and profuse references given. A few well-chosen illustrations are given. The book is not too big; is well written and an easy and handy reference.

ADVANCES IN INTERNAL MEDICINE. Editor, J. Murray Steele, M.D., Welfare Hospital, New York University Division, Welfare Island, N. Y. Associate editors, William Dock, M.D., Department of Pathology, Cornell University Medical College, New York, N. Y.; Tinsley R. Harrison, M.D., Bowman Gray School of Medicine, Wake Forest College, Winston-Salem, N. C.; Chester S. Keefer, M.D., Evans Memorial, Massachusetts Memorial Hospitals, Boston, Mass.; Robert F. Loeb, M.D., College of Physicians and Surgeons, Columbia University, New York, N. Y.; Warfield T. Longcope, M.D., The Johns Hopkins Hospital, Baltimore, Md., George R. Minot, M.D., Thorndike Memorial Laboratory, Boston City Hospital, Boston, Mass.; I. Snapper, M.D., Peiping Union Medical College, Peiping, China. Volume 1. New York: Interscience Publishers, Inc., 1942. Price, $4.50.

This is a collection of rather complete monographs on various advances in medical science and practice. These are prepared by individuals who have contributed in such advance, well done, and in not too technical language. This volume discusses the use of the Miller-Abbott tube in treatment and diagnosis of gastro-intestinal disorders by W. Osler Abbott; insulin and protamine insulin in treatment of diabetes by Paul H. Laviates; sympathetic nervous control of the peripheral vascular system by Robert W. Wilkins; antibacterial action of the sulfonamide drugs, by Colin M. McLeod; choice of sulfonamides in the treatment of infection by Chester S. Keefer; infections of the urinary tract by Lowell A.

Rantz; hypertension: a review of humoral pathogenesis and clinical treatment by Irvine H. Page and A. C. Corcoran, and several other reviews of equal interest. This is the first volume of a series which will be decidedly valuable.

MEDICAL PARASITOLOGY. By James T. Culbertson, Assistant Professor of Bacteriology, College of Physicians and Surgeons, Columbia University. Pages xvi and 285. New York: Morningside Heights, Columbia University Press, 1942. Price, $4.25.

All parasitic animals which have an influence on health, and which live upon or invade the human body are described, mostly pictured, and their life, modes of propagation and prevention of invasion clearly and interestingly given. The book makes one familiar with the animal, whether it is a single cell or a complicated organism. Methods of diagnosis and treatment, as well as steps to prevent infection, are freely and completely described. The book is a handy reference for the practitioner and a good textbook for the student. It is finely printed and bound, and would be an acceptable addition to any medical library.

THE ANSWER IS—YOUR NERVES. By Arnold S. Jackson, M.D., F.A.C.S., with a chapter by the Rev. Edwin O. Kennedy. Illustrations by Evelyn Lipman. Madison, Wisconsin: Kilgore Printing Co., 1942. Price $2.00.

Why be secretary of your luncheon club when you do not want to be? Maybe you are nervous because you are not only working under high tension, but are subjected to continuous interruptions. This modern life is so fast, but the man living it can restrain himself, and live longer. If the pace is killing, relax. There are patients complaining of tight necks or shortness of breath. Some want operations and some have a fear of operations. Dr. Jackson gives us a very readable book, not technical in words, but sensible in ideas. It can be given to our "nervous" patient and can be understood by him, with a little insight on the part of the doctor in selecting his patients. It is stated that one out of every fifteen persons in the state of New York spends seven years in a hospital for nervous diseases. A little foresight and a little careful guidance can relieve many of these. The relation of religion and nerves is discussed, and the increasing sympathy between the two professions.

NUTRITION AND CHEMICAL GROWTH IN CHILDHOOD. Volume I. Evaluation. Icie G. Macy, Ph.D., Director of the Research Laboratory of the Children's Fund of Michigan, Consultant for nutrition to the pediatric staff of the Children's Hospital of Michigan. Former Secretary of the American Institute of Nutrition. With a foreword by Hugo A. Freund, M.D., President, Board of Trustees, Children's Fund of Michigan. Springfield, Illinois: Charles C. Thomas, 1942. Price, $5.00.

This is volume one of an exhaustive study of the chemistry and other biological facts in growth and development of childhood. The opportunity for study was used to accumulate a tremendous mass of facts and information, which is presented in great detail. Children were placed in homes and schools where their every action could be recorded. Intake and excreta of foods, chemicals, metals, were studied to determine

influence on growth. Blood determinations, and the study of white and red cell variance at different hours of the day and night, and under conditions of rest or emotion—all this was done to determine influence on the studies being made. Thousands of studies, experiments and investigations were made, and they are classified, tabulated and made available in this book. If any line of enquiry into child growth, nutrition, diet, and effects of rest or recreation was missed it would be a surprise. The book is complete and factual, the studies varied. Methods are described, and when needed, are invented. They are given in sufficient detail to be a guide for others to follow. Years were required for this study by a corps of trained laboratory workers, and the results are of extreme value.

SULFANILAMIDE AND RELATED COMPOUNDS IN GENERAL PRACTICE. By Wesley W. Spink, M.D., F.A.C.P., Associate professor of medicine, University of Minnesota Medical School. Chicago: The Year Book Publishers, Inc., 1942. Price $3.00.

The sulfonamides and their use in treatment have come so rapidly, and have filled our literature so thoroughly that it is impossible for the average doctor to keep abreast of this branch of therapy. A book to have gone into a revised and rewritten second edition in just two years must have some decided merit. General principles of the drug and its use are given, together with its chemical structure, and the variations making up the other sulfonamide compounds. Doses, methods of treatment, indications, selection of the sulfonamide to use are carefully and completely covered in the text, covering over three hundred pages. There is a fifty-five page section on bibliography. Treatment for venereal infections is carefully given, and reasons for some failures. Dr. Spink does not claim twenty-four-hour cures, but does tell of very successful prophylactic use in 800 cases with only one failure. The book is a systematic and easily accessible treatise on sulfonamide therapy, and brings this latest advance of medicine into our easy reach.

A TEXTBOOK OF GYNECOLOGY. By Arthur Hale Curtis, M.D., Professor and Chairman of the Department of Obstetrics and Gynecology, Northwestern University Medical School; Chief of the Gynecological Service, Passavant Memorial Hospital, Chicago. Fourth Edition. Reset with 401 illustrations, Chiefly by Tom Jones. Philadelphia and London: W. B. Saunders Company, 1942. Price $8.00.

This new, enlarged fourth edition of Doctor Curtis' textbook, first published in 1930, is one of the most comprehensive single volumes on this subject. Many valuable illustrations of pelvic anatomy and pathology are found among its 690 pages.

Important addition to this edition include further anatomical plates and descriptions, an evaluation of sulfonamide therapy in infections, and a review of modern endocrine therapy in gynecological conditions requiring supportive or replacement therapy. New endocrine products, synthetic drugs are evaluated, and familiar preparations reviewed.

The pathology and management of uterine tumors and carcinoma of the cervix in particular has been enlarged upon, with an excellent demonstration of radical hysterectomy for malignancy. The revised section on ovarian tumors is the most important addition to this volume. This is a valuable book.

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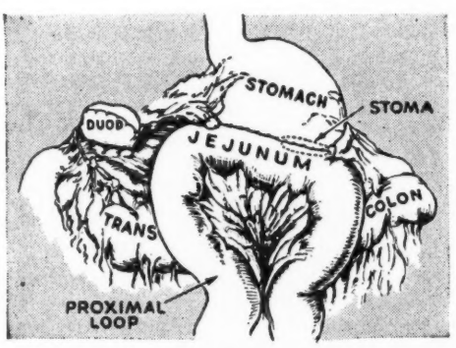

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1. *Fauley, G. B.; Freeman, S.; Ivy, A. C.; Atkinson, A. J.; and Wigodsky, H. S.;* Aluminum Phosphate in the Therapy of Peptic Ulcer, Arch. Int. Med. 67: 563-578 (March) 1941.
2. *Marshall, S. F., and Devine, J. W. Jr.;* Gastrojejunal Ulcer, S. Clin. North America, 743-761 (June) 1941.

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